

PLEASE WRITE PLAINLY IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**M-245**  
**53 6501** **51-30717** **BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH** **Registered No. 53 6501**

**BIRTH NO.**

**1. NAME OF DECEASED** (Type or Print) *MacLean, Neil John*

**2. DATE OF DEATH** *17 July 1953*

**3. PLACE OF DEATH:**  
**A. Baltimore City, Maryland** ✓

**4. USUAL RESIDENCE** (Where deceased lived, if institution; residence before admission)  
**A. STATE** *Maryland* **B. COUNTY**

**5. FULL NAME OF HOSPITAL OR INSTITUTION** (If not in hospital or institution, give street address or location)  
*Union Memorial Hospital*

**6. CITY OR TOWN** (If outside corporate limits, write RURAL and give township)  
*Baltimore*

**7. STREET ADDRESS** (If rural, give location)  
*3830 Rexmore Rd.*

**c. Length of stay in Baltimore** *19* Yrs. Mos. Days

**8. SEX** *M* **9. COLOR OR RACE** *W* **10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)** *Single*

**11. DATE OF BIRTH** *Dec. 16, 1951* **12. AGE (In years last birthday)** *19* If Under 1 Year Months Days If Under 24 Hours Hours Min.

**13. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

**14. KIND OF BUSINESS OR INDUSTRY** *none*

**15. BIRTHPLACE** (State or foreign country) *Maryland* **16. CITIZEN OF WHAT COUNTRY?** *USA.*

**17. FATHER'S NAME** *Neil John McLean, Sr.* **18. MOTHER'S MAIDEN NAME** *Mary Patricia Caulfield*

**19. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no or unknown) *No* **20. SOCIAL SECURITY NO.**

**21. INFORMANT ADDRESS**

**18. 180X CAUSE OF DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
 (A) *Hypostatic pneumonia* **INTERVAL BETWEEN ONSET AND DEATH** *2 days*

**ANTECEDENT CAUSES**  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
 (B) *Generalized Peritonitis*  
 (C) *Obstruction & perforation of bowel*

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.** *Embryoma, left kidney*

**19A. DATE OF OPERATION**  
 ① *6-10-53* ② *7-6-53* ③ *7-13-53*

**19B. MAJOR FINDINGS OF OPERATION**  
*Embryoma left kidney. Intestinal obstruction due to post-op adhesion.*

**20. AUTOPSY?** ☒ YES ☐ NO

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** ☐ YES ☐ NO

**21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.)

**21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME (Month) (Day) (Year) (Hour) OF INJURY**

**21E. INJURY OCCURRED**  
 WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**21F. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from** *6 June*, 1953, to *17 July*, 1953, that I last saw the deceased alive on *17 July*, 1953, and that death occurred at *12:20* A.M., from the causes and on the date stated above.

**23A. SIGNATURE** *Thos. A. Mosely, Jr.* **23B. ADDRESS** *Union Memorial Hosp.* **23C. DATE SIGNED** *17 July 53*

**24A. BURIAL, CREMATION, REMOVAL (Specify)** *Burial* **24B. DATE** *7/21/53* **24C. NAME OF CEMETERY OR CREMATORY** *Cambridge Cem* **24D. LOCATION (City, town, or county) (State)** *Cambridge Mass.*

**DATE RECEIVED BY LOCAL REGISTRAR** *7/21/53* **REGISTRAR'S SIGNATURE** *Huntington* **25. FUNERAL DIRECTOR ADDRESS** *John A. Moran 3000 E. Balto & W. N. Lawrence*





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6502**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**Thomas William GROSS**2. DATE  
OF  
DEATH**July 16, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION**VA HOSPITAL****BALTIMORE 18, MARYLAND**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE**MARYLAND**

B. COUNTY

C. CITY OR TOWN

**BALTIMORE**

D. STREET ADDRESS (If rural, give location)

**1940 FRANKLIN STREET,**

c. Length of stay in Baltimore

**35**Yrs.  
Mons.  
Days

5. SEX

**MALE**

6. COLOR OR RACE

**NEGRO**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**MARRIED**

8. DATE OF BIRTH

**MARCH 31, 1897**9. AGE (in years  
last birthday)**56**If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**BARTENDER**10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**CHURCHTON, MARYLAND**12. CITIZEN OF  
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

**ALEXANDER GROSS**

14. MOTHER'S MAIDEN NAME

**ROSE NICK**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, oo or unknowns) (If yes, give war or dates of service)**Yes****9/1918 - 1/28/19**16. SOCIAL  
SECURITY NO.**UNKNOWN**

17. INFORMANT

ADDRESS

**VA HOSPITAL RECORDS VAH, BALTO. 18, MD.**18. **002 X**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **PULMONARY TUBERCULOSIS FAR ADVANCED  
ACTIVE**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.**TUBERCULOUS PERITONITS****UNKNOWN**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY**VA**

m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **MAY 1**, 1953, to **JULY 16**, 1953, and that death occurred at **11:50 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**JOHN T. KALISH**

23B. ADDRESS

**N. D. VAH BALTIMORE 18, MARYLAND**

23C. DATE SIGNED

**7/16/53**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**Burial**

24B. DATE

**7/18/53**

24C. NAME OF CEMETERY OR CREMATORY

**Franklin**

24D. LOCATION (City, town, or county)

**Churchton Md**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

**750 6M**

8-1002

BATHING WITH HEALTH SURVEILLANCE

CERTIFICATE OF DEATH

8-1002

THOMAS J. JONES

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6503**

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|--|---|---|--|--|--|
| BIRTH NO. <b>53 6503</b>   |   | 1. NAME OF DECEASED<br>(Type or Print) <b>HERBST Margaret Elizabeth</b>   |  | 2. DATE OF DEATH <b>July 16 1953</b>                                     |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>St. Josephs Hospital</b>  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Josephs Hospital Balto Md.</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |  |  |
| c. Length of stay in Baltimore   |   | D. STREET ADDRESS (If rural, give location)<br><b>506 Cording Ave # 12</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>                    | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>April 16, 1897</b>                                    | 9. AGE (in years last birthday)<br><b>56</b>                             | 10. Under 1 Year<br>Months: Days   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Pittsburgh, Pennsylvania</b> |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>August Herbst</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Philomena Tragessor</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   |   | 16. SOCIAL SECURITY NO.   |  | 17. INSTANT ADDRESS<br><b>Marcella Herbst, 506 Cording Avenue</b>        |  |
| 18. <b>447X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Pulmonary edema</b><br>DUE TO        |   | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arterial Hypertension</b><br>DUE TO   |   | (B)   |  | (C)  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |   |  |  |  |
| 19A. DATE OF OPERATION <b>0</b>  |   | 19B. MAJOR FINDINGS OF OPERATION  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>July 16, 1953</b> , to <b>July 16, 1953</b> , that I last saw the deceased alive on <b>July 16, 1953</b> , and that death occurred at <b>5:15 p.m.</b> , from the causes and on the date stated above. |   |   |  |  |  |
| 23A. SIGNATURE<br><b>R. Cassinelli</b>   |   | 23B. ADDRESS<br><b>St. Josephs Hospital</b>   |  | 23C. DATE SIGNED<br><b>July 16 1953</b>                                  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 24B. DATE<br><b>7-17-53</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Georges</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Pittsburgh, Pa.</b>      |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 16 1953</b>  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Wm. Cook Inc.</b>  |  | ADDRESS<br><b>1217 St. Paul St.</b>                                      |  |

DECLARATION OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6504**

**M-500**  
**53 6504** **51-02249**

|  |                                  |  |  |  |   |                                       |                                 |                                     |
|--|----------------------------------|--|--|--|---|---------------------------------------|---------------------------------|-------------------------------------|
| BIRTH NO.  |                                  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY PAUL MUNN</b>   |  |   | 2. DATE OF DEATH <b>July 17, 1953</b> |                                 |                                     |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |   |                                       |                                 |                                     |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>                                  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Owings Mill</b>   |  |   |                                       |                                 |                                     |
| c. Length of stay in Baltimore<br><b>2 1/2</b> Yrs. Mos. Days  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>Caves Road</b>   |  |   |                                       |                                 |                                     |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>Jan. 28, 1951</b>   |  | 9. AGE (In years last birthday)<br><b>2 1/2</b>                         | If Under 1 Year<br>Months Days        | If Under 24 Hours<br>Hours Min. |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |                                       | 12. CITIZEN OF WHAT COUNTRY?    |                                     |
| 13. FATHER'S NAME<br><b>Charles A. Munn, Jr</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Loretta Strauff</b>   |  |   |                                       |                                 |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Charles A. Munn, Jr</b>                             |                                       |                                 | ADDRESS<br><b>Owings Mills, Md.</b> |

|   |                |                                  |
|---|----------------|----------------------------------|
| 18. <b>E830.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute fibrinous peritonitis secondary to Multiple injuries sustained in truck accident</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES   | (A) DUE TO     |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (B) DUE TO     |                                  |
|   | (C) DUE TO     |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                |                                  |

|   |   |   |   |   |
|---|---|---|---|---|
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home-driveway</b> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Owings Mills, Md.</b>  |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>July 16, 1953</b>   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><b>Run over by dairy truck backing into driveway</b>  |   |   |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |   |   |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b> M.D.  |   | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |   | 23C. DATE SIGNED<br><b>July 17, 1953</b>  |
| 24A. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>July 18, 1953</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b> |   |

|  |  |  |                                  |
|--|--|--|----------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 18 1953</b> | REGISTRAR'S SIGNATURE<br><b>Huntington H. Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Wm. H. Williams &amp; Son</b> | ADDRESS<br><b>805 N. Calvert</b> |
|--|--|--|----------------------------------|

V S 151 **N 869.2**

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 53 6505

RTH NO. 6505 53-16284  
NAME OF DECEASED (Type or Print) BABY GIRL FLETCHER 2. DATE OF DEATH JULY 17, 1953

PLACE OF DEATH: Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MARYLAND B. COUNTY \_\_\_\_\_

FULL NAME OF (If not in hospital or institution, give street address or location)  
OSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND BALTIMORE C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 21-02

D. STREET ADDRESS (If rural, give location) 1304 Glyndon Ave  
Length of stay in Baltimore Since BIRTH Yrs. 4 Mos. 0 Days 0

SEX Female 6. COLOR OR RACE WHITE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 8. DATE OF BIRTH JULY 13, 1953 9. AGE (In years last birthday) 4 DAYS If Under 1 Year Months: Days Hours: Min.

A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) child 10B. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME Earl Fletcher 14. MOTHER'S MAIDEN NAME Mildred Meiser

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. --- 17. INFORMANT Earl Fletcher ADDRESS 1304 Ave Glyndon

18. 754.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH PULMONIC STENOSIS INTERVAL BETWEEN ONSET AND DEATH Since Birth 4 DAYS

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) CONGENITAL HEART DISEASE SINCE INCEPTION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ALSO PULMONARY ATELECTASIS Since birth 4 days

19A. DATE OF OPERATION 7 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from JULY 13, 1953 to JULY 17, 1953 that I last saw the deceased alive on JULY 17, 1953, and that death occurred at 4:35 p. m., from the causes and on the date stated above.

23A. SIGNATURE William D. Rossen 23B. ADDRESS 1204 Lutheran Hospital of Md 23C. DATE SIGNED JULY 17, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/18/53 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park 24D. LOCATION (City, town, or county) (State) Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR 10/18 REGISTRAR'S SIGNATURE Huntington Williams 25. FUNERAL DIRECTOR John J. Cowan ADDRESS 1908 St. Hollins

STATE OF NEW YORK  
COUNTY OF ALBANY  
In SENATE  
January 11, 1900  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 11, 1899  
ALBANY: J.B. LEECH, STATE PRINTER.  
1900.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

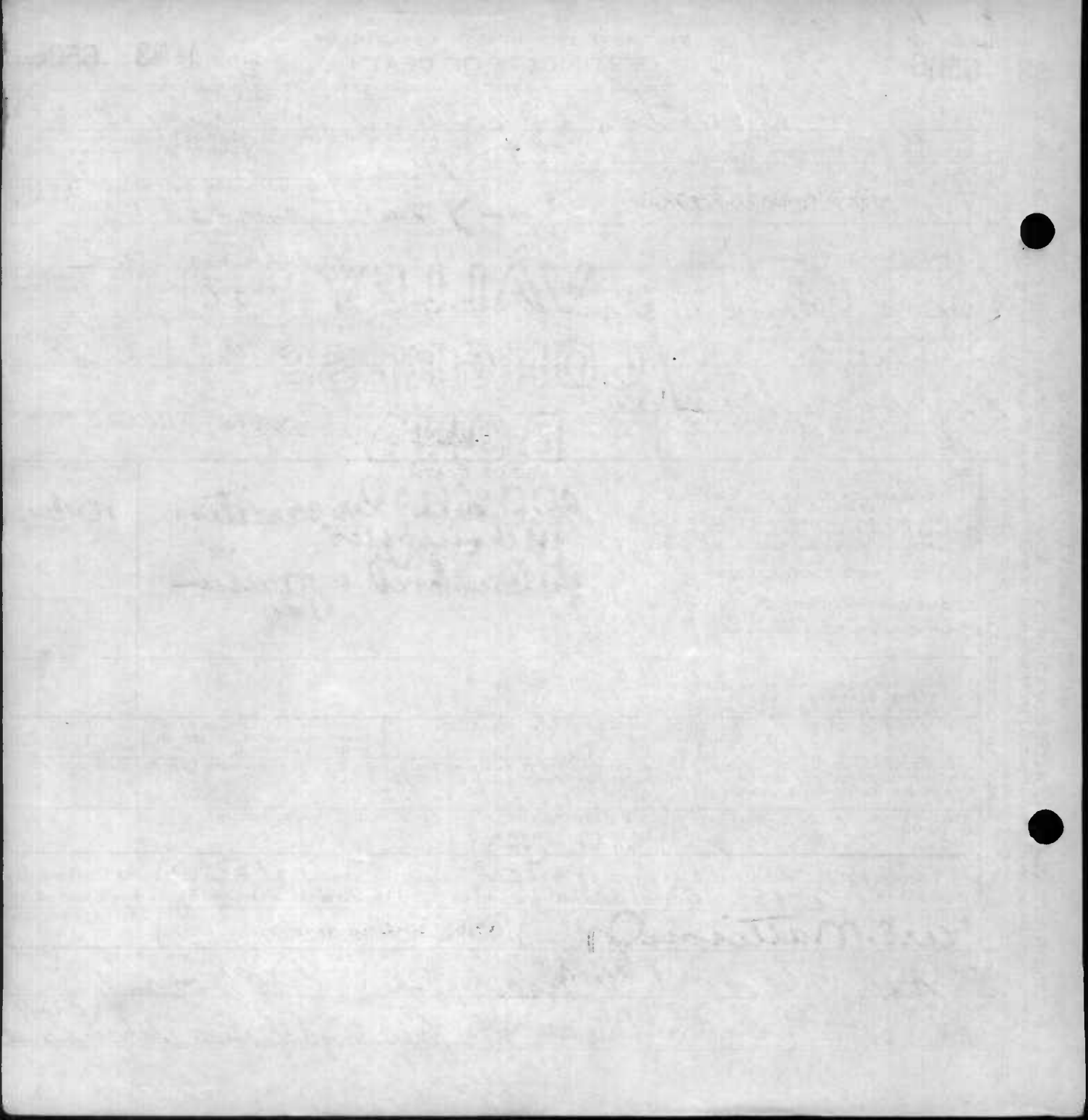
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6506

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6506

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Dorothy Branch</i>   |                                    | 2. DATE OF DEATH<br><i>July 15, 1953</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Med. Inst.</i>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD.</i><br>B. COUNTY <i>Baltimore</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>   |  |
| c. Length of stay in Baltimore<br>Yrs. <i>33</i><br>Mos. <i>11</i><br>Days <i>9</i>                                  |                                    | D. STREET ADDRESS (If rural, give location)<br><i>1197 Dutton Ave</i>  |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>9-9-26</i>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>      |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><i>26</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Goldsboro N.C.</i>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Samson Scarlett</i>  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Anna Cox</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i> |                                    | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                    | ADDRESS  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. <i>340.3</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><i>Emphysema, Pericarditis, Meningitis</i>                     |  | CAUSE OF DEATH<br>(A) <i>Emphysema, Pericarditis, Meningitis</i><br>DUE TO<br>(B) <i>Unidentified organism</i><br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>10 days</i>                       |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>7-2-</i> , 19 <i>53</i> , to <i>7-15-</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7-15-</i> , 19 <i>53</i> and that death occurred at <i>2:30 p.m.</i> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><i>W.E. Mattison Jr.</i>   |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |  | 23C. DATE SIGNED   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><i>7/18/1953</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Goldsboro Cem</i>               |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Goldsboro N.C.</i>   |  |   |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>Jul 18 1953</i>   |  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |  | 25. FUNERAL DIRECTOR<br><i>Mr. Katie R. Williams</i>                     |  |
| VS 150   |  | ADDRESS<br><i>Schroeder St</i>  |  |  |  |



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-524  
53 6507

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6507

BIRTH NO.

|  |                           |   |  |  |                                       |
|--|---------------------------|---|--|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)   |                           | Miss Mary Leimkuhler                                      |  | 2. DATE OF DEATH<br>July 16, 1953  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Beech Hill Nursing Home<br>Beechland and Old Harford Road     |                           |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br>Baltimore                           |                                       |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           |   |  | D. STREET ADDRESS (If rural, give location)<br>3501 White Avenue   |                                       |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>single |  | 8. DATE OF BIRTH<br>Aug. 16, 1870  | 9. AGE (In years last birthday)<br>82 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home   |                           | 10B. KIND OF BUSINESS OR INDUSTRY                         |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland   |                                       |
| 13. FATHER'S NAME<br>John M. Leimkuhler  |                           |   |  | 12. CITIZEN OF WHAT COUNTRY?   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                           |   |  | 14. MOTHER'S MAIDEN NAME<br>Barbara Knapp  |                                       |
| 16. SOCIAL SECURITY NO.  |                           |   |  | 17. INFORMANT<br>Mrs. Helen E. Reed, 3116 Weaver Avenue  |                                       |

|  |  |   |  |  |
|--|--|---|--|--|
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | CAUSE OF DEATH<br>(A) Anterior Circulatory<br>Cardio-Vascular Disease<br>(B)<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 year |
|--|--|---|--|--|

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| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  |  |
| 19A. DATE OF OPERATION<br>0  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>m.  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from 1-14, 1951, to 7-16, 1953, that I last saw the deceased alive on 7-15, 1953, and that death occurred at 6 P. M., from the causes and on the date stated above.

|   |  |   |  |
|---|--|---|--|
| 23A. SIGNATURE<br>R. W. Peck                        |  | 23B. ADDRESS<br>4568 Harford Rd                               | 23C. DATE SIGNED<br>7-17-53                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 24B. DATE<br>July 20, 1953                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery  | 24D. LOCATION (City, town, or county)<br>Baltimore, Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR                    | REGISTRAR'S SIGNATURE<br>Washington Williams | 25. FUNERAL DIRECTOR<br>Edward J. Peck, 5305 Harford Road #14 |  |

1050 8

1050 8

4508 Xajal Rd.  
Dr Peak  
6-8



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-526

53 6508

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6508  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Catherine E. Ringrose

2. DATE  
OF  
DEATH

July 16, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4319 Valley View Avenue

C. CITY OR TOWN (If outside corporate limits, write LOCAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4319 Valley View Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

March 26, 1875

9. AGE (In years,  
last birthday)

78

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Bankard

14. MOTHER'S MAIDEN NAME

Josephine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. John E. Ringrose, 4353 Shamrock Avenue

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular System  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/13, 1953, to 7/16, 1953, that I last saw the  
deceased alive on 7/16, 1953, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 20, 1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery Baltimore, Maryland

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

8022

8022

3a Taglia  
Belair

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| L-100<br>6509   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | Registered No. 53 6509   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | Edwin S. Levy  |  | 2. DATE OF DEATH<br>JUL 18 1953  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | Hal 5 - (Hal 3)  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE N.Y.<br>B. COUNTY V-29 |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>JOHNS HOPKINS HOSPITAL   |  | C. CITY OR TOWN<br>New York  |  | D. STREET ADDRESS (If rural, give location)<br>226 E. 12th. St.  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |  | 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>white  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>S.   |  | 8. DATE OF BIRTH<br>2-3-31   |  | 9. AGE (In years last birthday)<br>22  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Driving Instructor   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Mitile Auto Driving   |  | 11. BIRTHPLACE (State or foreign country)<br>New York  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>Harry Levy  |  | 14. MOTHER'S MAIDEN NAME<br>Dora Janikowitz  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)<br>no   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |
| 18. 754.4 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | CAUSE OF DEATH<br>(A) Cerebrovascular thrombosis, postoperative<br>(B) Congenital cyanotic heart disease 22 yrs.<br>(C)  |  | INTERVAL BETWEEN ONSET AND DEATH<br>36 hrs.  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br>7/16/53   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Congenital heart disease   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                 |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |  |
| 21F. HOW DID INJURY OCCUR?  |  | 22. I hereby certify that I attended the deceased from 7-13-1953 to 7-18-1953 that I last saw the deceased alive on 7-18-1953 and that death occurred at 6:45 P.M. from the causes and on the date stated above. |  |  |  |
| 23A. SIGNATURE<br>William K. Nelson   |  | 23B. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |  | 23C. DATE SIGNED<br>7/18/53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>removal  |  | 24B. DATE<br>July 18, 1953   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Mount Hebron Cemetery  |  |
| 24D. LOCATION (City, town, or county)<br>New York City.   |  | 24E. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |  | 24F. ADDRESS<br>2601-3-5 E. Madison St.  |  |
| 25. DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 18 1953   |  | 25. REGISTRAR'S SIGNATURE<br>Huntington Williams   |  | 25. ADDRESS<br>VS 150  |  |

093 83

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5-524  
53 6510

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6510  
Registered No.

BIRTH NO.

|  |                              |  |   |  |  |
|--|------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type in Print) <b>SWINGLER ANDREW</b>  |                              |  | 2. DATE OF DEATH<br><b>July 14, 53</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Univ. Hosp.</b>   |                              |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>University of Maryland Hospital</b> |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-44</b>                                  |  |  |
| C. Length of stay in Baltimore <b>(LIFE)</b>   |                              |  | D. STREET ADDRESS (If rural, give location)<br><b>3502 E. White Ave 14</b>  |  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)<br><b>(WIDOWED)</b> | 8. DATE OF BIRTH<br><b>OCT. 30. 1874</b>  |  | 9. AGE (In years last birthday)<br><b>79</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>                  |                              |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>             |
| 13. FATHER'S NAME<br><b>John. SWINGLER</b>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE ?</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                       |                              |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Albert Swingler 3502 White Ave</b> |

|  |                |                                  |
|--|----------------|----------------------------------|
| 18. <b>154X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Adenocarcinoma of the recto-sigmoid with combined abdominal perineal resection (6 yrs ago) &amp; metastatic</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES  | (A) DUE TO     |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (B) DUE TO     |                                  |
|  | (C) DUE TO     |                                  |

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| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  |   |
| 19A. DATE OF OPERATION<br><b>8/14/46</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>cancer of recto-sigmoid</b>                        | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from **July 14, 1953** to **7-16, 1953** that I last saw the deceased alive on **19** and that death occurred at **2:30 P** m., from the causes and on the date stated above.

|  |   |  |
|--|---|--|
| 23A. SIGNATURE<br><b>Marion F. DeVeneria</b>                       | 23B. ADDRESS<br><b>Univ. Hosp.</b>  | 23C. DATE SIGNED<br><b>7/17/53</b>                         |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>         | 24B. DATE<br><b>7/20/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b> |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md.</b> | 25. FUNERAL DIRECTOR<br><b>Huntington Williams, Paul Robinson 6067 Hayford Rd</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>7/18</b>                    |   |  |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>                |   |  |

WATLEY

WATLEY

WATLEY

WATLEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-650  
53 6511

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6511

|   |                                    |  |                                     |   |                               |
|---|------------------------------------|--|-------------------------------------|---|-------------------------------|
| BIRTH NO.   |                                    | 1. NAME OF DECEASED<br>(Type or Print) <i>Evelyn Brown</i>   |                                     | 2. DATE OF DEATH <i>July 17, 1953</i>                                       |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY |                                     |   |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 9-09</i>                  |                                     |   |                               |
| c. Length of stay in Baltimore <i>16 yrs.</i>   |                                    | D. STREET ADDRESS (If rural, give location)<br><i>1814 N. Caroline St.</i>   |                                     |   |                               |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>  | 8. DATE OF BIRTH<br><i>7-4-1910</i> | 9. AGE (In years last birthday)<br><i>43</i>                                | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife at home</i>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>Georgetown S.C., U.S.A.</i> |                               |
| 13. FATHER'S NAME<br><i>Leopold Bakker</i>  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Isabella Winglass</i>   |                                     | 12. CITIZEN OF WHAT COUNTRY?  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |                                    | 16. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>                      |                               |
| 18. <i>561.3 and 214X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) <i>Intestinal obstruction</i><br>DUE TO<br>(B) <i>Incisional hernia</i><br>DUE TO<br>(C) |                                    | INTERVAL BETWEEN ONSET AND DEATH   |                                     |   |                               |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <i>Uterine fibroids</i><br>(C)  |                                    | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.         |                                     |   |                               |
| 19A. DATE OF OPERATION <i>7/16</i>  |                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II      |                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |                                     | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |                                     | 21F. HOW DID INJURY OCCUR?  |                               |
| 22. I hereby certify that I attended the deceased from <i>6/16</i> , 19 <i>53</i> , to <i>7/17</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7/17</i> , 19 <i>53</i> and that death occurred at <i>4.25 A.M.</i> , from the causes and on the date stated above.  |                                    |  |                                     |   |                               |
| 23A. SIGNATURE<br><i>Henry N. Wagner, Jr.</i>   |                                    | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                     | 23C. DATE SIGNED<br><i>7/17/53</i>  |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                    | 24B. DATE<br><i>7/20/53</i>  |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Midway Cem.</i>                    |                               |
| 24D. LOCATION (City, town, or county) (State)<br><i>Georgetown S.C.</i>   |                                    | 24E. FUNERAL DIRECTOR<br><i>Huntington Williams, 414 Long St.</i>  |                                     | 24F. ADDRESS<br><i>Wilson 1100</i>  |                               |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 18 1953</i>  |                                    | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>  |                                     | 25. FUNERAL DIRECTOR<br><i>Wilson 1100</i>                                  |                               |

VS 150

*Beatty and*

1970

STATE OF NEW YORK

OFFICE

STATE OF NEW YORK

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STATE OF NEW YORK

OFFICE

53

PLEASE WRITE PLAINLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 6512**

**P-620**  
**6512**  
BIRTH NO.

|  |                                  |  |  |  |  |
|--|----------------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JOSEPH FRANK PIWROSKI</b>   |                                  |  | 2. DATE OF DEATH<br><b>July 16, 1953</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>California</b><br>B. COUNTY <b>V-04</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b>   |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Los Angeles</b>   |  |  |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>1910 W. 9th Street</b>   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>10/4/1920</b>   | 9. AGE (In years last birthday)<br><b>32</b> | If Under 1 Year Months: _____ Days: _____<br>If Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>        |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>S.S. Exmia</b>           | 11. BIRTHPLACE (State or foreign country)<br><b>Worcester, Mass.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br>_____  |
| 13. FATHER'S NAME<br><b>Anthony Piuorski</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Michaelsky</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>0</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>18-12-3394</b>                     | 17. INFORMANT ADDRESS<br><b>Alice Doherty 2 Gardner Pl Worcester</b>   |  |  |

18. **E853X**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Fracture of skull**  
**DUE TO Subdural hemorrhage, left**  
**Contusion foci of brain**  
(B) **Atelectasis, left**

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
**ship**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**Pier #6, Clinton Street**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
**July 16, 1953 3:00 P. m.**

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? **Fell 40' from mast to deck**

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jachimczyk**

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED  
**July 17, 1953**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Remove**

**7/17/53**

**Notre Dame Cem.**

**Worcester Mass**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**11/18**

**Huntington Williams, Mortuary & Cook Inc. Baltimore**

VS 151

**N803.2**

**56455**

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



|  |  |   |  |  |  |
|--|--|---|--|--|--|
| -523<br>6513   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 53 6513<br>Registered No.  |  |
| NAME OF DECEASED<br>(Last, first, middle or Print)   |  | JAMES A. CONSIDINE  |  | 2. DATE OF DEATH<br>7/16/53  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>MD |  | B. COUNTY<br>BALTO   |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>3019 Barclay St  |  | C. CITY OR TOWN<br>BALTO  |  | D. STREET ADDRESS (If rural, give location)<br>3019 Barclay St           |  |
| Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |  | 8. DATE OF BIRTH<br>MARCH 26, 1898  |  | 9. AGE (In years last birthday)<br>55                                    |  |
| 10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED  |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                      |  |
| 13. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br>MILES MAN   |  | 14. MOTHER'S MAIDEN NAME<br>HANNIE F. KELLY   |  | 15. FATHER'S NAME<br>JAMES F. CONSIDINE                                  |  |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>NO  |  | 16. SOCIAL SECURITY NO.<br>217-05-1794  |  | 17. INFORMANT<br>HELEN S CONSIDINE 3019 BARCLAY ST                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CORONARY THROMBOSIS |  | 19. CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO<br>ANTERIOR MYOCARDIAL INFARCTION          |  | INTERVAL BETWEEN ONSET AND DEATH<br>SUDDEN                               |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7/16, 1953 to 7/16, 1953 that I last saw the deceased alive on 7/16, 1953, and that death occurred at 8:35 AM, from the causes and on the date stated above.        |  |   |  |  |  |
| 23A. SIGNATURE<br>Joseph H. Zwick  |  | 23B. ADDRESS<br>2318 Euteria Place  |  | 23C. DATE SIGNED<br>7/17/53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 24B. DATE<br>7/20/53  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                      |  |
| 24D. LOCATION (City, town, or county)<br>BALTO MD  |  | 24E. LOCATION (City, town, or county)<br>BALTO MD   |  | 24F. LOCATION (City, town, or county)<br>BALTO MD                        |  |
| 25. FUNERAL DIRECTOR<br>Huntington Williams  |  | 25. FUNERAL DIRECTOR<br>CHARLES F. EVANS & SON  |  | 25. FUNERAL DIRECTOR<br>ADDRESS<br>4906 E 18th W. Mt. Royal Ave.         |  |

810



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6514  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM ZIEGLER

2. DATE  
OF DEATH July 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1307 Valley St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Baltimore City Morgue

C. CITY OR TOWN (If outside corporate limits, write R.R. and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1307 Valley Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

June 1895

9. AGE (in years  
last birthday)

58

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Land scape Gardener

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Zeigler

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Alma Zeigler 610 Gutman Ave

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an partial autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Joseph A. Guilinger, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

July 17, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 18, 1953

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

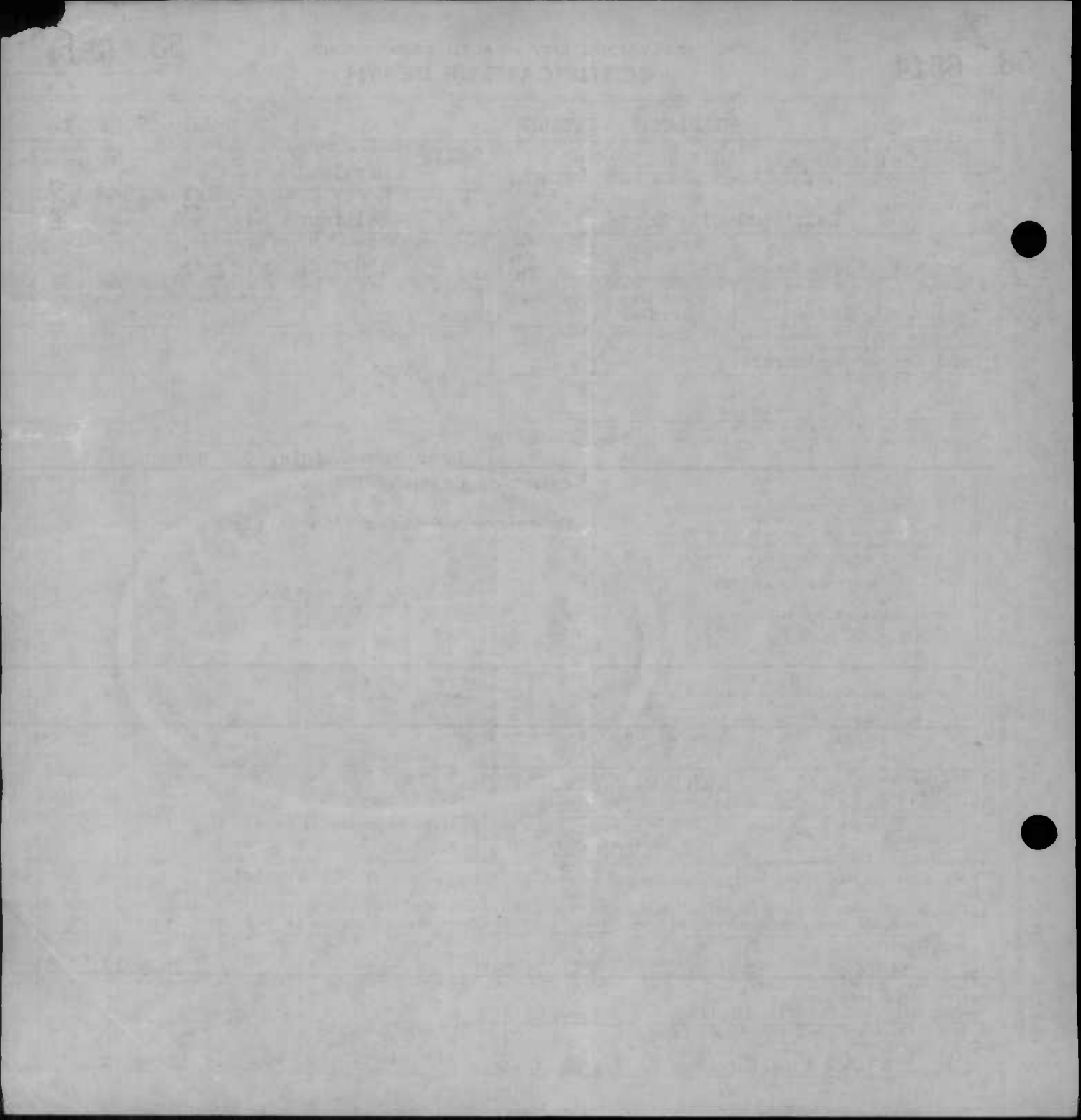
Huntington Williams 1415 Hta Wiedefeld 900 E. Biddle St

VS 151

93010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6515

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNIE GRANT MYERS

2. DATE  
OF  
DEATH

July 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Hospital for Homeless of Md.

C. Length of stay in Baltimore

2

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

10-26-1869

9. AGE (in years  
last birthday)

83

10. Under 1 Year  
Months: Days:11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR  
INDUSTRY

-

13. FATHER'S NAME

Augustus Harman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Ray Myers - Westminster, Md.

18. 490X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Lobar Pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Hypertensive Atherosclerotic  
Cardiovascular Disease.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 16, 1953, to July 18, 1953, that I last saw the  
deceased alive on July 18, 1953, and that death occurred at 7:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. Dugan

23B. ADDRESS

HOSP. FOR WOMEN OF MD.

23C. DATE SIGNED

7/18/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

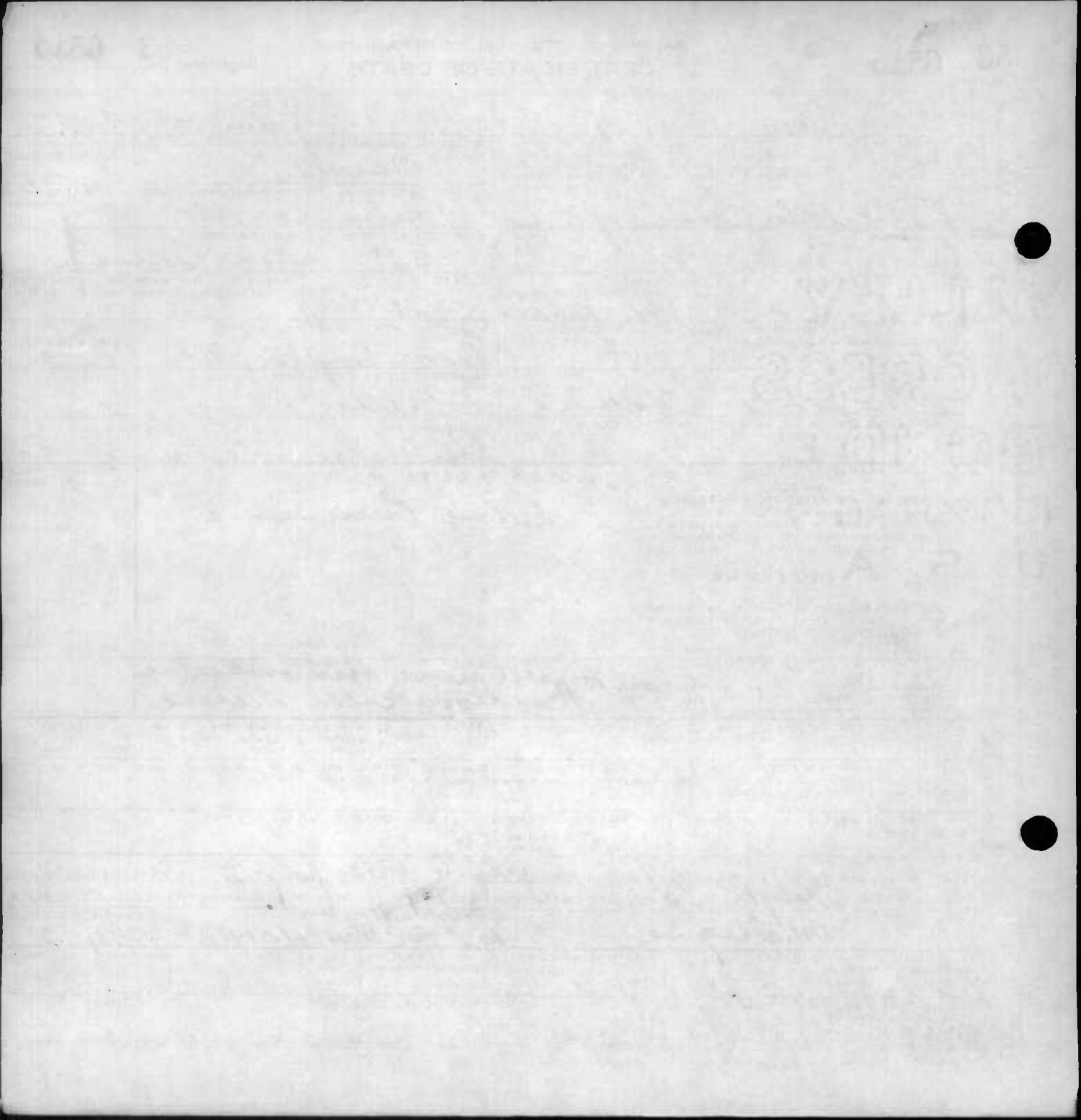
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Burial July 21, 53 Pipe Creek Cemetery, Rural, New Windsor, Md.  
Huntington Williams, M.D. Joe S. Sargent, Jr. Westminster, Md.



H-400  
53 6516BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6516

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                             |  |  |   |  |  |  |
|--|-----------------------------|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)   |                             | Alesia Barlow Hall   |  | 2. DATE OF DEATH  |  | July 18, 1953                          |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)     |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |                             |  |  | A. STATE<br>Maryland  |  |  |  |
| 1552 Argyle Ave.   |                             |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore |  |  |  |
| c. Length of stay in Baltimore 43 yrs.   |                             |  |  | D. STREET ADDRESS (If rural, give location)<br>1552 Argyle Ave.                           |  |  |  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed |  | 8. DATE OF BIRTH<br>Mar. 17, 1861   |  | 9. AGE (In years, last birthday)<br>92 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home                  |  | 11. BIRTHPLACE (State or foreign country)<br>Washington D. C.                             |  | 12. CITIZEN OF WHAT COUNTRY?           |  |
| 13. FATHER'S NAME<br>Arthur Simmons  |                             |  |  | 14. MOTHER'S MAIDEN NAME<br>Alice Robinson  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   |                             | 16. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS                                |  |
|  |                             |  |  | Miss Louise B. Barlow-1552 Argyle Ave   |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CARDIO VASCULAR DISEASE |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 YRS                                |  |
| (A) DUE TO  |  | (B) DUE TO   |  | (C) DUE TO   |  |
| ANTECEDENT CAUSES   |  |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from Apr. 24, 1953 to July 18, 1953 that I last saw the deceased alive on JUNE 24, 1953, and that death occurred at 3 A. m., from the causes and on the date stated above.            |  |  |  |  |  |
| 23A. SIGNATURE<br>William Frey M. D.  |  | 23B. ADDRESS<br>1928 Penna Ave   |  | 23C. DATE SIGNED<br>7/18/53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>7-23-1953   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem. Cem.                  |  |
| 24D. LOCATION (City, town, or county)<br>Washington, D. C.  |  | 24E. FUNERAL DIRECTOR<br>Mcguire, Funeral Home-1820 9th St. N.W.                                       |  | 24F. ADDRESS<br>Washington D. C.   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 19 1953   |  | REGISTRAR'S SIGNATURE<br>Huntington Williams   |  |  |  |

0170 23

0170 23

7



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

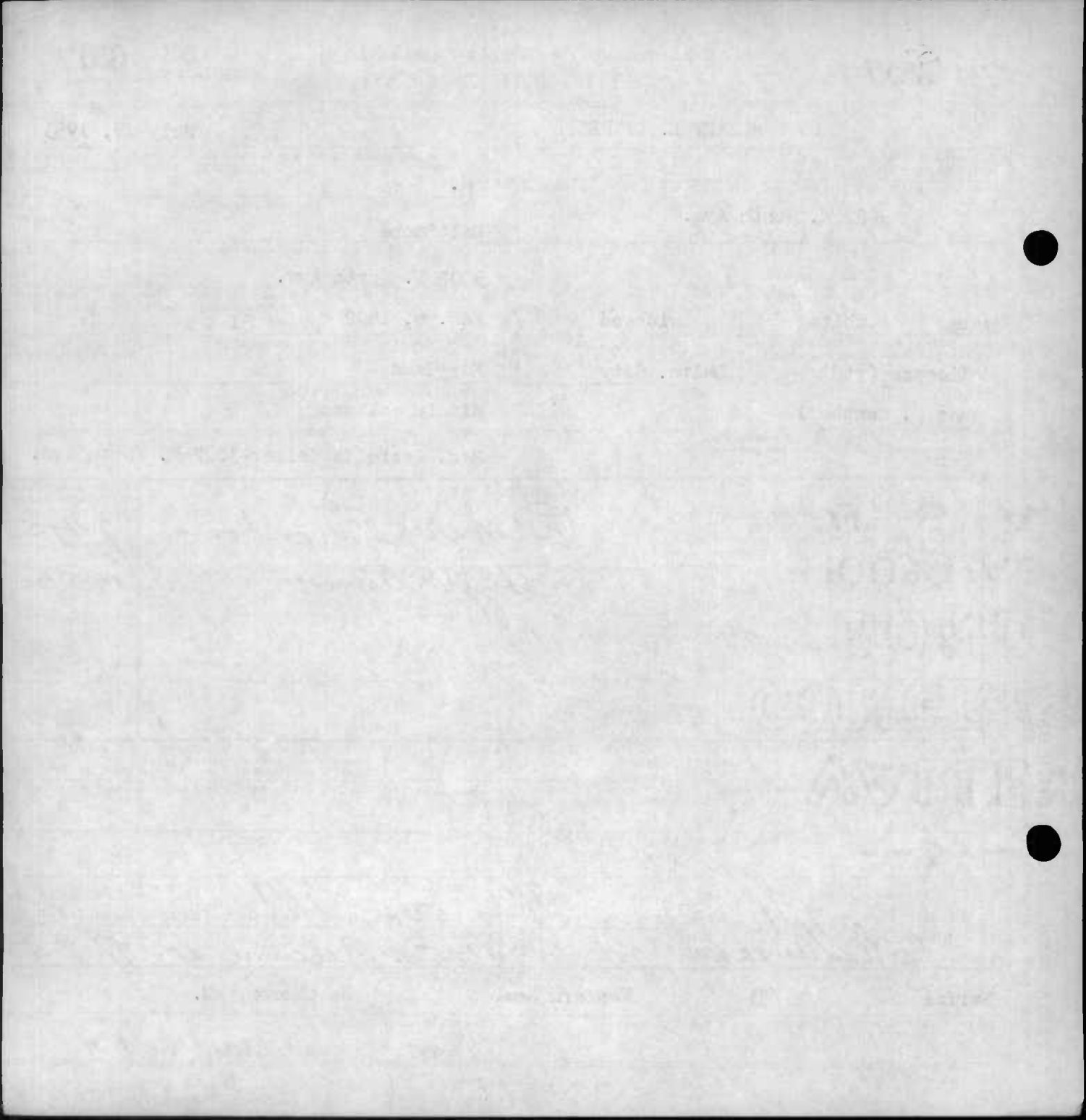
MARGIN RESERVED FOR BINDING

53 6517

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6517  
Registered No.

|   |  |  |
|---|--|--|
| BIRTH NO.   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |  |
| ROBERT L. CAMPBELL  |  |  |
| 2. DATE OF DEATH  |  |  |
| July 17, 1953   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md.  |  |  |
| B. COUNTY   |  |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore   |  |  |
| D. STREET ADDRESS (If rural, give location)<br>3002 W. North Ave.   |  |  |
| 5. SEX<br>male  |  |  |
| 6. COLOR OR RACE<br>white   |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed  |  |  |
| 8. DATE OF BIRTH<br>Feb. 6, 1892  |  |  |
| 9. AGE (In years last birthday)<br>61   |  |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Policeman (rtd)   |  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME<br>James F. Campbell  |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Minnie Waltman  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>no  |  |  |
| 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT<br>Mrs. Isabella Keller-3002 W. North Ave.  |  |  |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Coronary Thrombosis<br>hypertension<br>INTERVAL BETWEEN ONSET AND DEATH<br>7/17-53<br>1952 |  |  |
| 19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |
| 19A. DATE OF OPERATION  |  |  |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |
| 19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |
| 21C. HOW DID INJURY OCCUR?  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |  |
| 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |
| 22. I hereby certify that I attended the deceased from 7/17, 1953, to 7/17, 1953, that I last saw the deceased alive on 7/17, 1953, and that death occurred at 5:30 P.M., from the causes and on the date stated above.   |  |  |
| 23A. SIGNATURE<br>Chas. A. Cahan  |  |  |
| 23B. ADDRESS<br>2145 W. Baltimore St.   |  |  |
| 23C. DATE SIGNED<br>7/18-53   |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |
| 24B. DATE<br>7/21/53  |  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Western Cem.  |  |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.   |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  |  |
| REGISTRAR'S SIGNATURE<br>Huntington Williams  |  |  |
| 25. FUNERAL DIRECTOR<br>Thm. J. Lickner & Sons  |  |  |
| ADDRESS<br>Balto 17, Md.  |  |  |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6518  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNE SEERY CHANEY

2. DATE  
OF  
DEATH

July 16, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1708 Park Ave.

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

June 26, 1885

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Baby Sitter

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Patrick W. Seery

14. MOTHER'S MAIDEN NAME

Ann Morrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Spencer Seery - 45 Maryland Ave., Annapolis, Md.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral Infarction

18 months  
2 1/2 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension  
Arteriosclerosis  
Myocarditis

Gradual

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 9, 1952, to July 16, 1953 that I last saw the deceased alive on 7/16, 1953, and that death occurred at 9:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

7/20/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

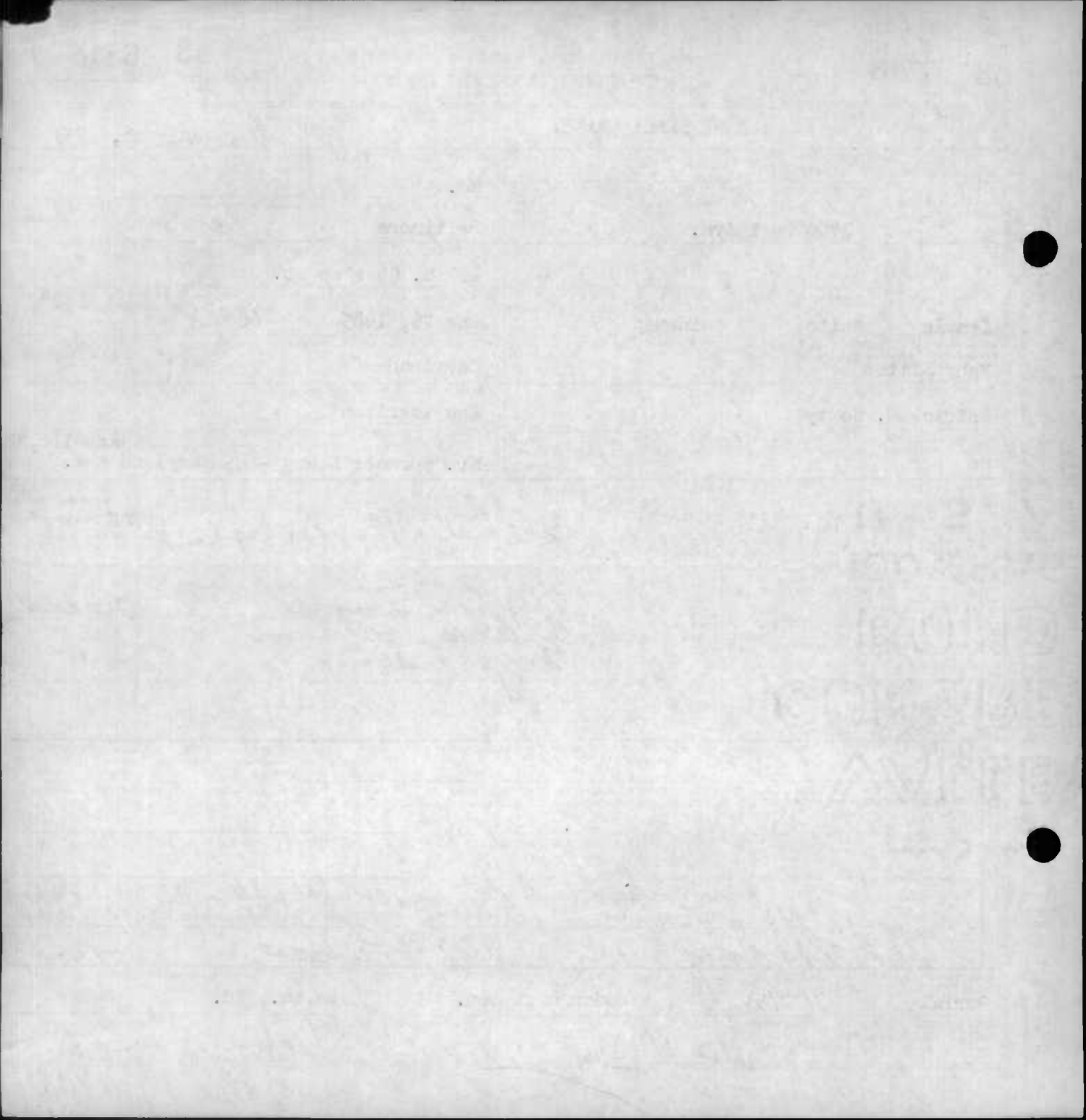
ADDRESS

Wm. J. Lickner & Sons

VS 150

7208A

Balto. 17, Md.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6519

BIRTH NO. N.R.

1. NAME OF DECEASED  
(Type or Print)

Annette Flood

2. DATE  
OF  
DEATH

7/17/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (not in hospital or institution, give street address or location)

University Hospital

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1-6-50

9. AGE (In years  
last birthday)

3

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Elijah Flood

14. MOTHER'S MAIDEN NAME

Manuel Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Elijah Flood 604 W. Conway St.

18. E902.0 and E885.0  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Cerebral edema, marked due to  
lead encephalopathy.  
DUE TO Cerebral edema due to fetal.(B) Contusion foci, temporal lobe, rt.  
DUE TO(C) Recent trephines rt. temporal  
decompressionINTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)604 W. Conway St.  
Hospital21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

6/15/53

21E. INJURY OCCURRED

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell from crib  
apparently ate paint22. I certify that I took charge of the remains described above, held an Autopsy, thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23. SIGNATURE

Joseph A. Jackson

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

7-25-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 1953

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

July 19/1953

Isaac L. Brown

Isaac L. Brown

VS 51 N853.2

108 W. Montgomery St.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 6520**

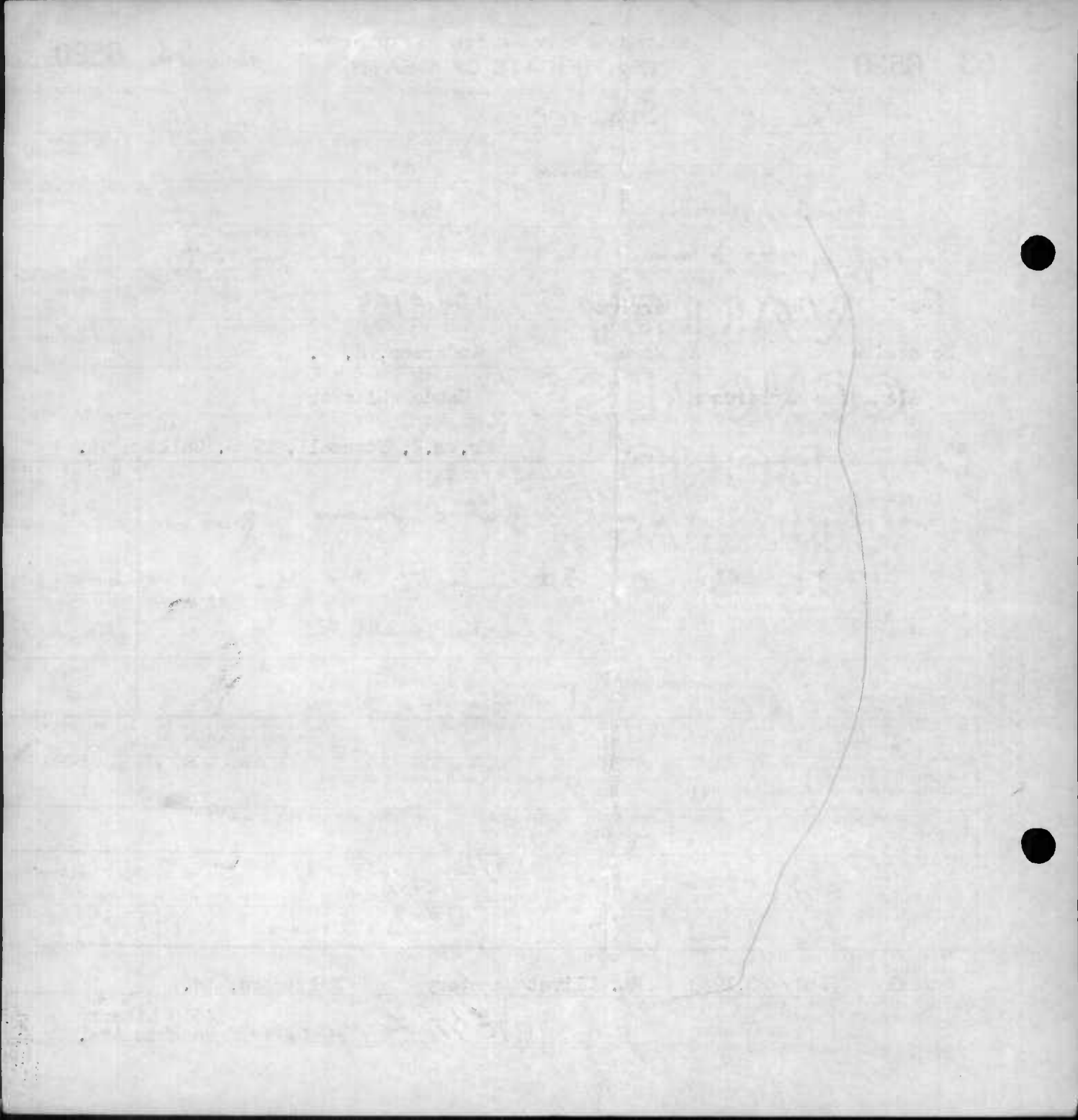
**53 6520**  
BIRTH NO.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WALLIE N. STANSELL</b>  |                                  | 2. DATE OF DEATH<br><b>7/17/53</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>Univ. Hosp.</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b> <b>19-03</b>                |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>27 S. Calhoun St.</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>12/19/99</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                       |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   | 9. AGE (In years last birthday)<br><b>53</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)<br><b>Anderson, S. C.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Alexander Richardson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Maude Whitaker</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                 |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT   |                                  | ADDRESS<br><b>Mr. Wm. H. Stansell, 27 S. Calhoun St.</b>  |   |

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 18. <b>260X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Compensative failure</b>                              |   | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3d.</b>                                      |   |
| DUE TO   |   | (A)  |  |   |   |
| ANTECEDENT CAUSES  |   | (B)  |  | <b>20 yrs (?)</b>   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | DUE TO   |  |   |   |
|  |   | (C)  |  | <b>(20 yrs ?)</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   | <b>Pneumonia, Uncomp.</b>  |  | <b>10d.</b>   |   |
| 19A. DATE OF OPERATION<br><b>None</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |   |
| 22. I hereby certify that I attended the deceased from <b>7/13</b> , 19 <b>53</b> to <b>7/17</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7/17</b> , 19 <b>53</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above. |   |  |  |   |   |
| 23A. SIGNATURE<br><b>J. H. Weir</b>  |   | 23B. ADDRESS<br><b>Univ. Hosp.</b>                                       |  | 23C. DATE SIGNED<br><b>7/17/53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 24B. DATE<br><b>July 20, 1953</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>              |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 20 1953</b>   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  | 25. FUNERAL DIRECTOR<br><b>E. M. Lemoine</b>                     |   | ADDRESS<br><b>4510 Liberty Heights Ave.</b> |

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



-351

6521

STEINBERG  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6521

Registered No.

IRTH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

Samuel Steinberg

2. DATE  
OF  
DEATH

7/18/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Jenai Hosp

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

4. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

15-11

D. STREET ADDRESS (If rural, give location)

3404 Rosedale Road

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec 15, 1893

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

Tailor

10b. KIND OF BUSINESS OR  
INDUSTRY

Shop

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

Morris Steinberg

14. MOTHER'S MAIDEN NAME

Sarah Berlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

220-20-4690

17. INFORMANT

Bessie J. Steinberg - 3404 Rosedale Road

ADDRESS

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Acute Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATH

2 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK

NOT WHILE  
AT WORK

22. I hereby certify that I attended the deceased from July 13, 1953 to July 18, 1953 that I last saw the  
deceased alive on July 18, 1953 and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Samuel Bakal M. D.

23B. ADDRESS

Sumner Hosp

23C. DATE SIGNED

7/18/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/19/53

24C. NAME OF CEMETERY OR CREMATORY

Shaare Zion Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hillman

25. FUNERAL DIRECTOR

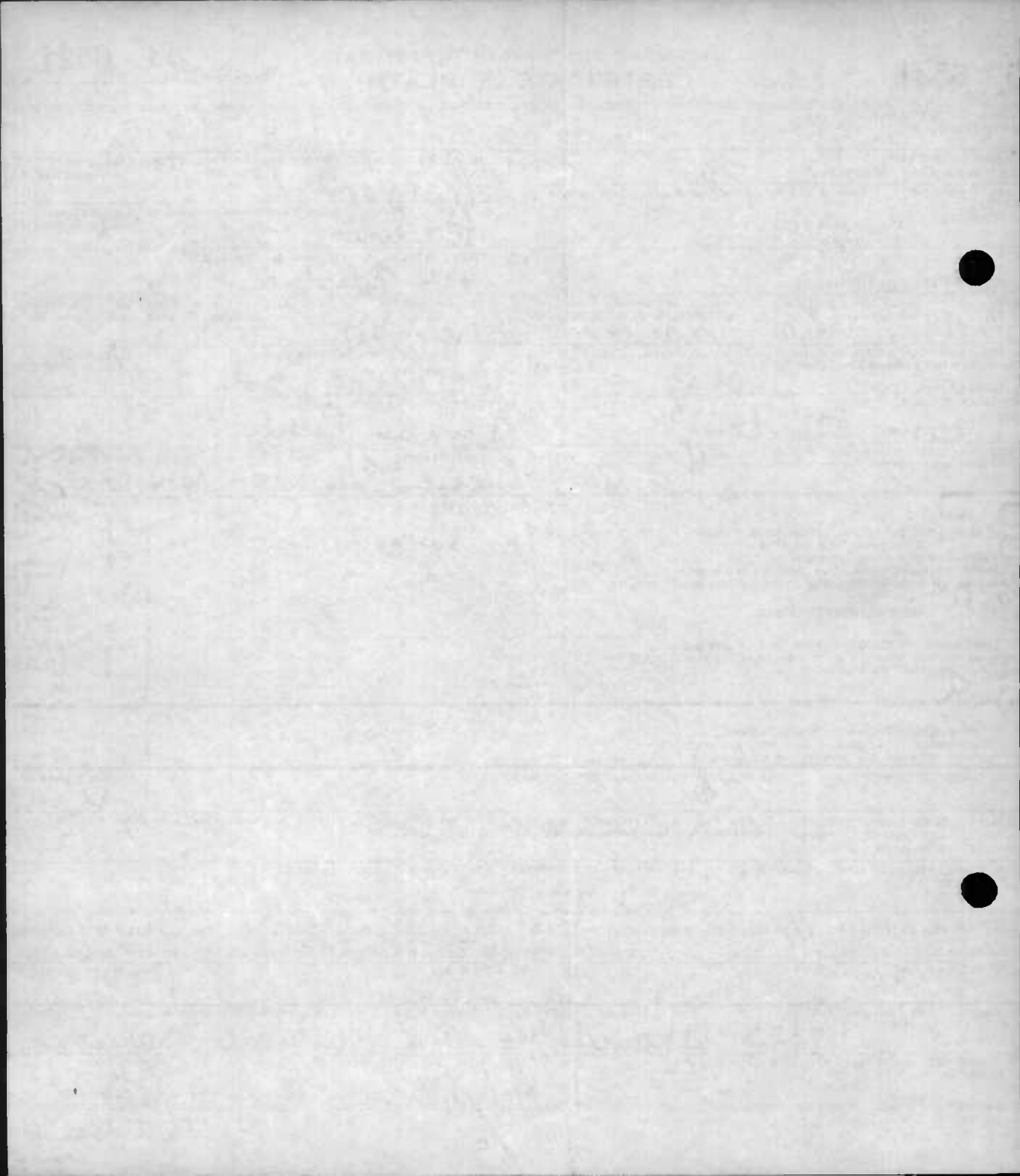
Vol Levinson + Bus - 1124-26 W.

ADDRESS

North Avenue

VS 150

5906E



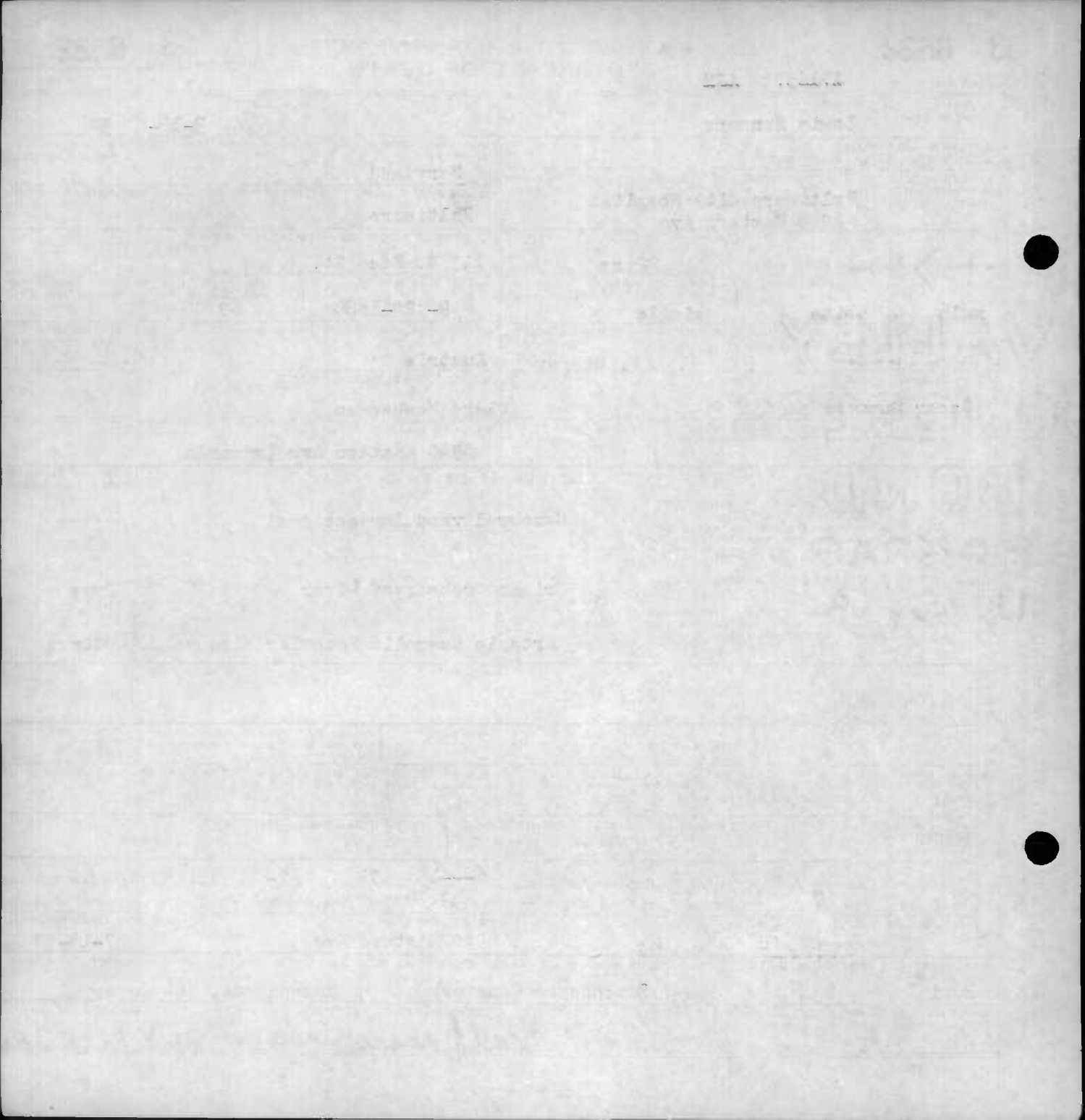
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                  |  |   | Registered No. <b>53 6522</b>  |   |
|--|----------------------------------|--|---|--|---|
| BIRTH NO. <b>171257 AJH</b>  |                                  |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lewis Summers</b>  |                                  |  | 2. DATE OF DEATH <b>7-18-53</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b><br><b>4940 Eastern Ave</b>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                  |  |   |
| c. Length of stay in Baltimore <b>22yrs</b>  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>113 N. Paca St.</b>   |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>   | 8. DATE OF BIRTH<br><b>9-24-1884</b>  | 9. AGE (in years last birthday)<br><b>69</b>                             | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>meat cutter</b>  |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>A. &amp; P. Stores</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Austria</b>   |
| 13. FATHER'S NAME<br><b>Oscar Summers</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Clara Newberge</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>4940 Eastern Ave (records)</b>  |  |   |
| 18. <b>331x and 155x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral vascular accident</b><br>DUE TO<br><b>Primary cancer of Liver</b><br><b>Arterio Sclerotic Vascular disease</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>25hrs</b><br><b>2yrs</b><br><b>10yrs</b>                                   |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arterio Sclerotic Vascular disease</b>  |                                  |  |   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |  |   |  |   |
| 19A. DATE OF OPERATION <b>7-18-53</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                       |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>      |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>6-15-1953</b> to <b>7-18-53</b> that I last saw the deceased alive on <b>7-18-53</b> and that death occurred at <b>2.30am</b> , from the causes and on the date stated above.  |                                  |  |   |  |   |
| 23A. SIGNATURE<br><b>H. J. Johnson</b>   |                                  | 23B. ADDRESS<br><b>4940 Eastern Ave</b>  |   | 23C. DATE SIGNED<br><b>7-18-53</b>                                       |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>July 19, 1953</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosenhayne Cemetery</b>         |   |
| 24D. LOCATION (City, town, or county)<br><b>Rosenhayne, New Jersey</b>   |                                  | 25. FUNERAL DIRECTOR ADDRESS (17)<br><b>Huntington Williams, H. J. Johnson &amp; Bro. 1124-26 W. North Ave</b> |   |  |   |

VS 150

690-6A





0-650

3 6523

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6523

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNIE C. BROWN</b>  |                           | 2. DATE OF DEATH <b>7/17/53</b>   |   |
| 3. PLACE OF DEATH: <b>Baltimore City, Maryland FRANKLIN SQ. HOSP.</b>   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>FRANKLIN SQUARE HOSP.</b> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 13-07</b>                      |   |
| 6. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days  |                           | D. STREET ADDRESS (If rural, give location)<br><b>828 W. 36th St.</b>   |   |
| 7. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH <b>12/21/1885</b>                        |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>                      |                           | 10. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>67</b>                 |
| 11. FATHER'S NAME<br><b>DECEASED - UNKNOWN</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.-A</b>   |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>-</b>                               |                           | 14. MOTHER'S MAIDEN NAME<br><b>DECEASED - UNKNOWN</b>   | 15. 17. INFORMANT ADDRESS<br><b>GORDON F. PULLER SAME</b> |
| 16. SOCIAL SECURITY NO.   |                           | 18. 19. 20.   |   |

|  |  |  |  |                                  |
|--|--|--|--|----------------------------------|
| 18. <b>570.2</b>   |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | (A) <b>GANGRENE OF INTESTINE</b>   |  |                                  |
| ANTECEDENT CAUSES  |  | (B) <b>MESENTERIC THROMBOSIS</b>   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (C) <b>GENERALIZED ARTERIOSCLEROSIS</b>                                  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | <b>OPERATION - COLOSTOMY</b><br><b>CORONARY INFARCTION, ANTERIOR</b>     |  |                                  |
| 19A. DATE OF OPERATION <b>7/1/53</b>   | 19B. MAJOR FINDINGS OF OPERATION<br><b>MESENTERIC THROMBOSIS</b>                                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |                                  |

22. I hereby certify that I attended the deceased from **7-1-**, 19**53** to **7-17**, 19**53** that I last saw the deceased alive on **7-16**, 19**53** and that death occurred at **1:00 p.m.**, from the causes and on the date stated above.

|   |   |   |
|---|---|---|
| 23A. SIGNATURE<br><b>[Signature]</b>                          | 23B. ADDRESS<br><b>FRANKLIN SQUARE HOSPITAL</b>       | 23C. DATE SIGNED<br><b>7/17/53</b>                    |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>    | 24B. DATE<br><b>July 20/53</b>                        | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b> |
| 24D. LOCATION (City, town, or county)<br><b>Woodlawn, Md.</b> | 25. FUNERAL DIRECTOR<br><b>E. Bonoran-3818 Roland</b> | ADDRESS<br><b>ave</b>                                 |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T-200

53 6524

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6524

|   |                                  |  |                                  |
|---|----------------------------------|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MATTIE TISCIE</b>   |                                  | 2. DATE OF DEATH<br><b>June 17, 1953</b>   |                                  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>00</b>                                  |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |                                  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>No home</b>  |                                  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>N</b>  | 8. DATE OF BIRTH<br><b>U</b>     |
| 9. AGE (In years last birthday)<br><b>45</b>  |                                  | 10. If Under 1 Year Months Days If Under 24 Hours Hours Min.   |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>O</b>  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br><b>K</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| 13. FATHER'S NAME<br><b>W N</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>W</b>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |                                  |
| 17. INFORMANT   |                                  | ADDRESS  |                                  |
| 18. <b>581.1</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Chronic alcoholism</b><br><del>XXXXX</del><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) Fatty infiltration of liver</b><br>DUE TO<br><b>(C)</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |                                  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  |
| 21F. HOW DID INJURY OCCUR?  |                                  |  |                                  |
| 22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .  |                                  |  |                                  |
| 23A. SIGNATURE<br><i>William W. Brown</i>   |                                  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/> |                                  |
| 23C. DATE SIGNED<br><b>June 18, 1953</b>  |                                  |  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 24B. DATE  |                                  |
| 24C. NAME OF CEMETERY OR CREMATORY  |                                  | 24D. LOCATION (City, town, or county) (State)  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                  | REGISTRAR'S SIGNATURE  |                                  |
| 25. FUNERAL DIRECTOR  |                                  | ADDRESS  |                                  |

| ASSETS            |  | LIABILITIES       |  |
|-------------------|--|-------------------|--|
| Cash              |  | Capital           |  |
| Real Estate       |  | Debt              |  |
| Personal Property |  | Other Liabilities |  |
| Investments       |  |                   |  |
| Other Assets      |  |                   |  |
| Total             |  | Total             |  |

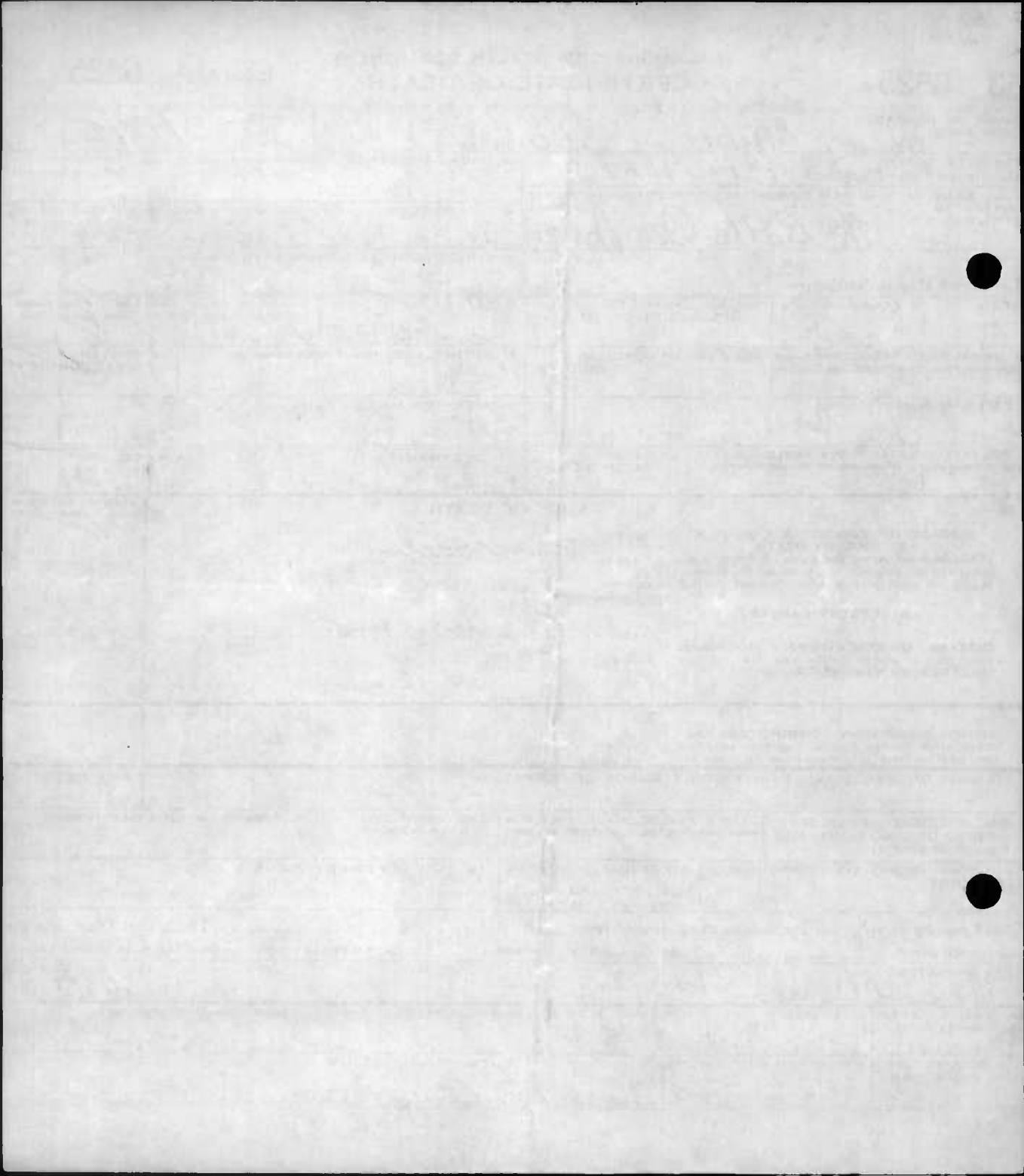
-200

## BALTIMORE CITY HEALTH DEPARTMENT

53 6525 53-00677 CERTIFICATE OF DEATH

Registered No. 53 6525

|   |                              |  |   |
|---|------------------------------|--|---|
| NAME OF DECEASED<br>(Type or Print) <b>Allen Michael Shockey</b>  |                              | 2. DATE OF DEATH<br><b>7/18/53</b>   |   |
| PLACE OF DEATH:<br>Baltimore City, Maryland <b>1213 Light St.</b>   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY   |   |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>South Balto. Gen. Hosp.</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Courtis Bay 25-04</b>   |   |
| Length of stay in Baltimore<br>Yrs. Mos. Days   |                              | D. STREET ADDRESS (If rural, give location)<br><b>3605 Evertt St</b>   |   |
| SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>N</b> | 7. SINGLE <input checked="" type="checkbox"/> MARRIED<br>WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH<br><b>Jan 13 1953</b>          |
| A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)  |                              | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (in years last birthday) <b>7 months</b> |
| FATHER'S NAME<br><b>Robert S. Shockey</b>   |                              | 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |   |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.  | 12. CITIZEN OF WHAT COUNTRY?                    |
| 18. <b>493X</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Alice J. Richardson</b>   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                              | 17. INFORMANT<br><b>Robt. S. Shockey</b>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                              | ADDRESS<br><b>3605 Evertt St</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                              | CAUSE OF DEATH<br><b>Pneumonia</b>   |   |
| 19A. DATE OF OPERATION <b>0</b>   |                              | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                              | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>  |   |
| 21F. HOW DID INJURY OCCUR?  |                              | 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above. |   |
| 23A. SIGNATURE<br><b>Ronald Dennis</b>  |                              | 23B. ADDRESS<br><b>M. D.</b>   |   |
| 23C. DATE SIGNED<br><b>7/18/53</b>  |                              | 24. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 24B. DATE<br><b>July 20 1953</b>   |   |
| 24C. LOCATION (City, town, pr county) (State)<br><b>Lanacoring Md</b>   |                              | 24D. FUNERAL DIRECTOR<br><b>Huntington, William</b>  |   |
| 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>7/19/53</b>   |                              | 24F. ADDRESS<br><b>1701-03 N Patterson Park</b>  |   |





250

63 6526

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6526

IRTH NO.

NAME OF DECEASED  
(Type or Print)

ESTHER RACHANOW

2. DATE  
OF  
DEATH

7-18-1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
STITUTION

T. SINAI HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

1-05

Length of stay in Baltimore

43

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

236 S. PATTERSON PK. AVE

SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

75

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Passy

12. CITIZEN OF  
WHAT COUNTRY?

U.S.G.

FATHER'S NAME

Joseph

14. MOTHER'S MAIDEN NAME

Freder

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Abraham Rachanow 236 S. Patterson Pk. Ave

18. 420.0 and 260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Embolus  
Cormany Heart Disease36 hours  
2 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)Arteriosclerotic Heart Disease  
Arteriosclerosis?  
?OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 1951, to 7-18, 1953 that I last saw the  
deceased alive on 7-17-1953. and that death occurred at 12:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

G. G. Inouman

M. D.

23B. ADDRESS

1109 N. Calvert St

23C. DATE SIGNED

7-18-53

A. BURIAL, CREMA-  
RY, REMOVAL (Specify)

BURIAL

24B. DATE

7-19-1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel

24D. LOCATION (City, town, or county)

BALTO.

MD

(State)

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

905 LEWIS INC - 2100 EUTAW PL.

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6527  
Registered No.

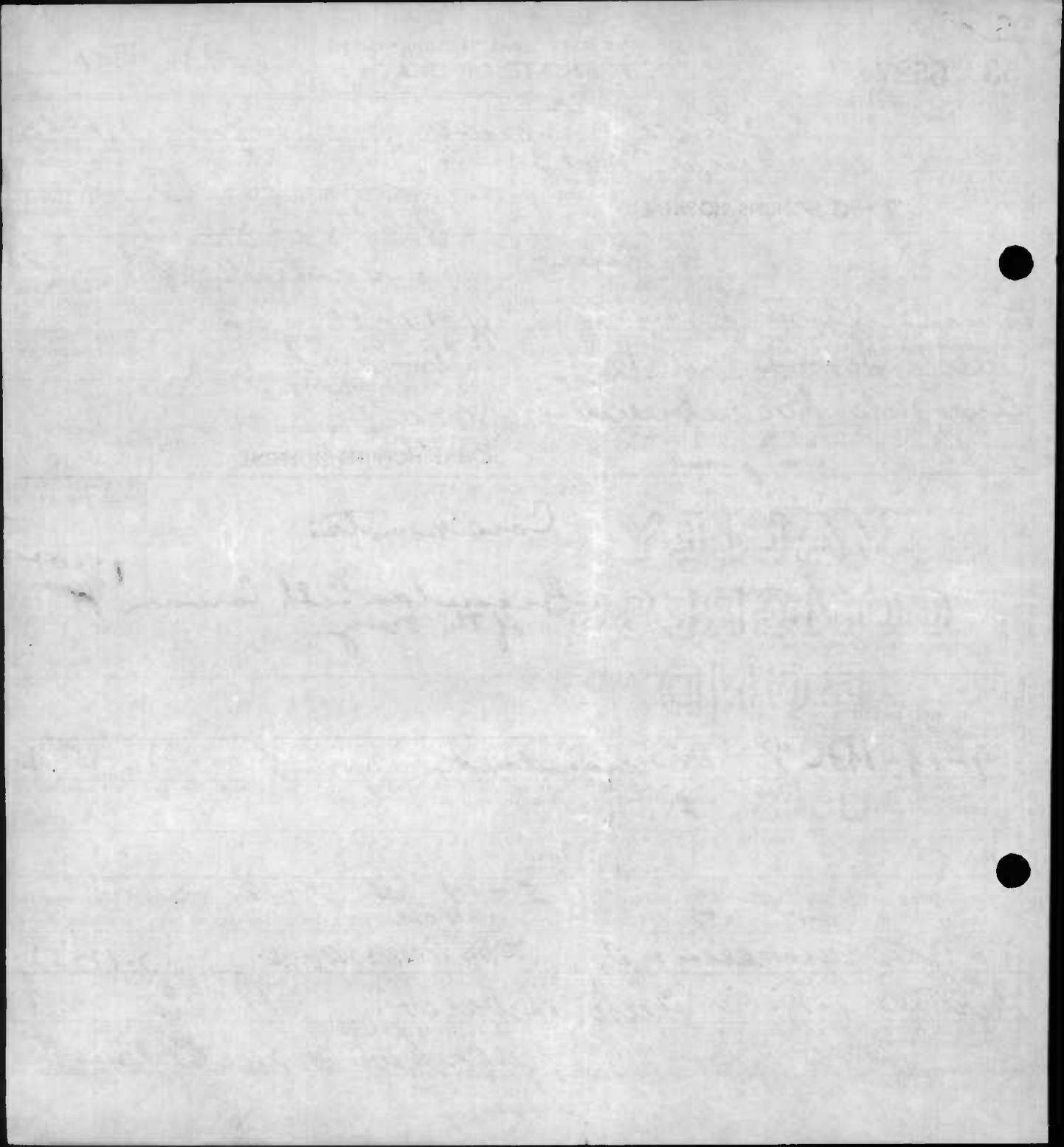
53 6527  
BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Esther Strauss</i>               |  | 2. DATE OF DEATH<br><i>July 12, 1953</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Bayview 3</i>         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> COUNTY <i>13-01</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 17</i>                              |  |
| D. STREET ADDRESS (If rural, give location)<br><i>Rochester Court Apts</i> |  | E. DATE OF BIRTH<br><i>11-12-'00</i>   |  |
| F. AGE (in years last birthday)<br><i>52</i>                               |  | G. Under 1 Year Months: Days: Hours: Min.  |  |
| H. Under 24 Hours Hours: Min.  |  | I. BIRTHPLACE (State or foreign country)<br><i>Balto - Md</i>  |  |
| J. CITIZEN OF WHAT COUNTRY?  |  | K. MOTHER'S MAIDEN NAME<br><i>Sora</i>   |  |
| L. FATHER'S NAME<br><i>Ben Zion Rosenbaum</i>                              |  | M. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)                        |  |
| N. SOCIAL SECURITY NO.   |  | O. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |  |

|   |   |  |
|---|---|--|
| 18. <i>175X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br><i>Carcinomatous</i><br>DUE TO<br>(A) <i>Grandma Cell Carcinoma of the Prox</i><br>(B) <i>of the Prox</i><br>(C) |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i>                        |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |
| 21A. DATE OF OPERATION<br><i>9-13-1952</i>  | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Grandma Cell</i>                                   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <i>5-14</i> , 19 <i>53</i> , to <i>7-17</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7-17</i> , 19 <i>53</i> , and that death occurred at <i>4:05 p.m.</i> , from the causes and on the date stated above.  |   |  |
| 23A. SIGNATURE<br><i>J. J. [Signature]</i>  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   | 23C. DATE SIGNED<br><i>7-17-53</i>                                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 24B. DATE<br><i>7-19-53</i>   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Balto Hebrew</i>                |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto Md</i>  | 25. FUNERAL DIRECTOR ADDRESS<br><i>2100 Eutan Rd</i>  |  |

MEDICAL CERTIFICATION

69092



-252

3 6528

**ROSENZWEIG**  
**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE CORRECTED DEATH**

53 6528  
Registered No.

IRTH NO.

NAME OF DECEASED (Please Print) *Joseph Rosenzweig* 2. DATE OF DEATH *7/18/53*

PLACE OF DEATH: *Baltimore City, Maryland* 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 5. STATE *Baltimore* 6. COUNTY *Baltimore*

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) *Anai Hosp* C. CITY OR TOWN *Baltimore* (If outside corporate limits, write RURAL and give township) *Met 15-11*

Length of stay in Baltimore 4. STREET ADDRESS (If rural, give location) *3629 Walbrook Ave*

SEX *M* 6. COLOR OR RACE *W* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Single* B. DATE OF BIRTH *June 11, 1893* 9. AGE (In years last birthday) *60* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) *Salesman* 10b. KIND OF BUSINESS OR INDUSTRY *Gen. Merchandise* 11. BIRTHPLACE (State or foreign country) *Boston, Mass* 12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

FATHER'S NAME *Abraham Rosenzweig* 14. MOTHER'S MAIDEN NAME *Anna*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT *Sam Rosenzweig, 3629 Walbrook Ave* ADDRESS

18. *163X* I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH *Pulmonary Carcinoma* INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO

II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE *Samuel Bakal* M. D. 23b. ADDRESS *Anai Hosp* 23c. DATE SIGNED *7/18/53*

24. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24b. DATE *7-19-53* 24c. NAME OF CEMETERY OR CREMATORY *Bellevue Resdale* 24d. LOCATION (City, town, or county) (State) *Baltimore, Md*

25. RECEIVED BY CAL REGISTRAR 25. REGISTRAR'S SIGNATURE *Huntington Williams* 25. FUNERAL DIRECTOR *Samuel Bakal* ADDRESS *2180-12 Entaw Place*

49068





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6529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 6529

Registered No.

TH NO.

NAME OF DECEASED (Last, first, middle, or Print)

PLACE OF DEATH:

Baltimore City, Maryland

Baltimore Md.

ULL NAME OF (If not in hospital or institution, give street address or location)

Bon Secours Hospital

Yrs.

Mos.

Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

19-03

6. STREET ADDRESS (If rural, give location)

336 S. Stricker St

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10/10/170

9. AGE (In years last birthday)

82

10. UNDER 1 Year

11. UNDER 24 Hours

12. CITIZEN OF WHAT COUNTRY?

USA

13. BIRTHPLACE (State or foreign country)

Ireland

14. MOTHER'S MAIDEN NAME

Catherine Curlin

15. FATHER'S NAME

Engene Fitzpatrick

16. SOCIAL SECURITY NO.

17. INFORMANT

18. DORA FITZPATRICK

336 S. STRICKER ST

19. DATE OF OPERATION

7/13/53

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8/53 to 7/10/53, that I last saw the deceased alive on 7/10/53, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. RECEIVED BY

26. REGISTRAR'S SIGNATURE

27. FUNERAL DIRECTOR

28. ADDRESS

VS 150

VS 820.0

ME. 01K 04 p.m.

PRA H + STRICKER STS

1. NAME OF DECEASED (Last, first, middle, or Print)

Mr Patrick Fitzpatrick

2. DATE OF DEATH

July 18<sup>th</sup> 1953

3. PLACE OF DEATH:

Baltimore City, Maryland Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

19-03

6. STREET ADDRESS (If rural, give location)

336 S. Stricker St

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10/10/170

9. AGE (In years last birthday)

82

10. UNDER 1 Year

11. UNDER 24 Hours

12. CITIZEN OF WHAT COUNTRY?

USA

13. BIRTHPLACE (State or foreign country)

Ireland

14. MOTHER'S MAIDEN NAME

Catherine Curlin

15. FATHER'S NAME

Engene Fitzpatrick

16. SOCIAL SECURITY NO.

17. INFORMANT

18. DORA FITZPATRICK

336 S. STRICKER ST

19. DATE OF OPERATION

7/13/53

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8/53 to 7/10/53, that I last saw the deceased alive on 7/10/53, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. RECEIVED BY

26. REGISTRAR'S SIGNATURE

27. FUNERAL DIRECTOR

28. ADDRESS

VS 150

VS 820.0

ME. 01K 04 p.m.

PRA H + STRICKER STS

1. NAME OF DECEASED (Last, first, middle, or Print)

Mr Patrick Fitzpatrick

2. DATE OF DEATH

July 18<sup>th</sup> 1953

3. PLACE OF DEATH:

Baltimore City, Maryland Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

19-03

6. STREET ADDRESS (If rural, give location)

336 S. Stricker St

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10/10/170

9. AGE (In years last birthday)

82

10. UNDER 1 Year

11. UNDER 24 Hours

12. CITIZEN OF WHAT COUNTRY?

USA

13. BIRTHPLACE (State or foreign country)

Ireland

14. MOTHER'S MAIDEN NAME

Catherine Curlin

15. FATHER'S NAME

Engene Fitzpatrick

16. SOCIAL SECURITY NO.

17. INFORMANT

18. DORA FITZPATRICK

336 S. STRICKER ST

19. DATE OF OPERATION

7/13/53

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8/53 to 7/10/53, that I last saw the deceased alive on 7/10/53, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. RECEIVED BY

26. REGISTRAR'S SIGNATURE

27. FUNERAL DIRECTOR

28. ADDRESS

VS 150

VS 820.0

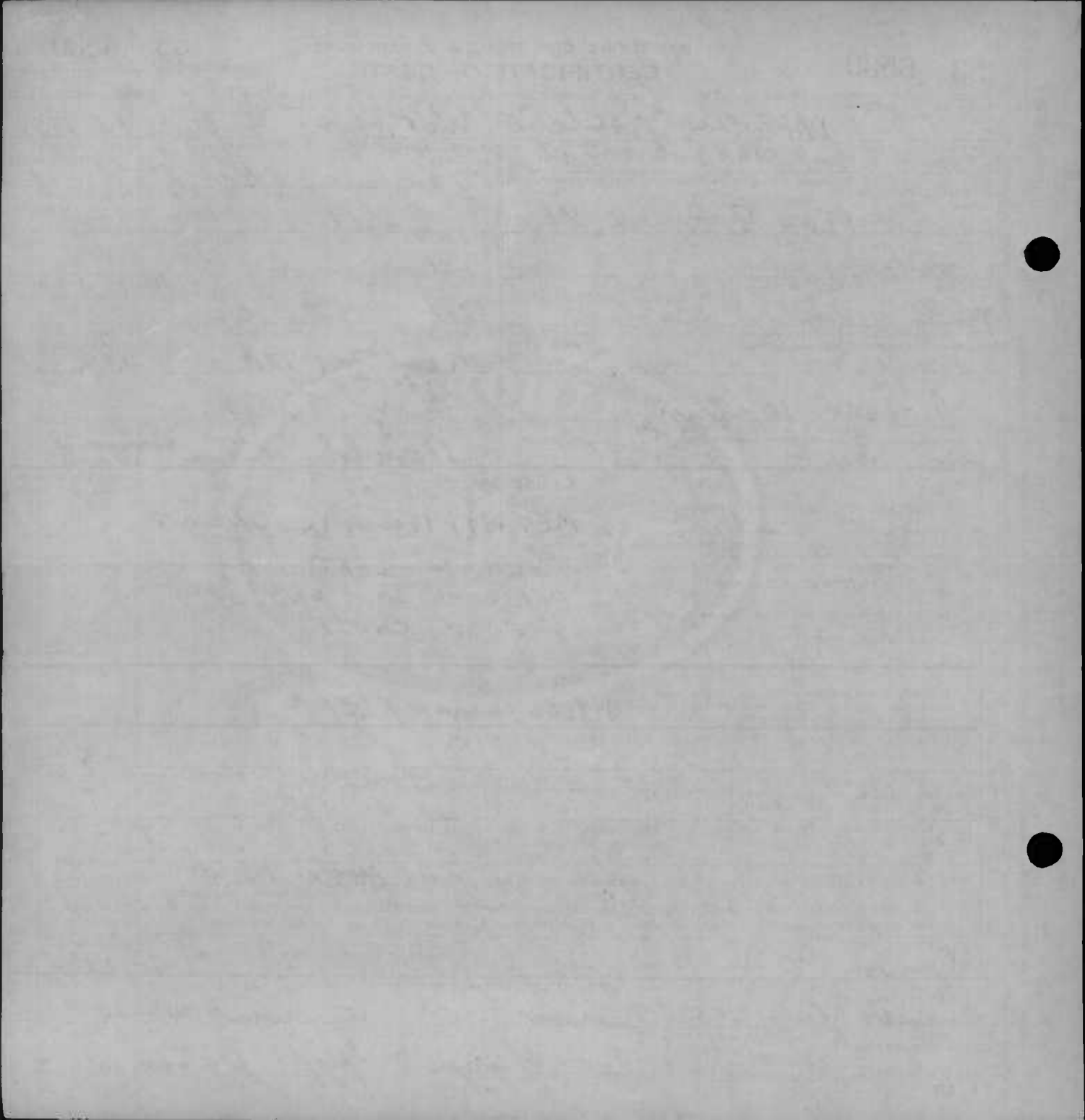
ME. 01K 04 p.m.

PRA H + STRICKER STS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6530  
Registered No.W-365  
53 6530  
BIRTH NO.

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>DARRELL MALCOLM WOTRING</b>   |                                  |   | 2. DATE OF DEATH <b>July 14 1953</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>1904 E. Pratt St.</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Garrett</b> |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1904 E. Pratt St.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Rural</b>  |   |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>Germania, Md.</b>   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>Dec. 7 1929</b>  |   | 9. AGE (In years last birthday) <b>24</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Woodman</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber.</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Kempton, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Ronald Watring</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Turek.</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes. War II</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>?</b>   |   |   |
| 17. INFORMANT<br><b>Ronald Watring, Germania, W. Va.</b>  |                                  |   | ADDRESS   |   |   |
| 18. <b>163X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) METASTATIC MALIGNANT TUMOR OF LEFT LUNG, PERICARDIUM, AND LEFT SIDE OF CHEST.</b>   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) HYDROTHORAX, LEFT</b>  |                                  |   |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |   |   |   |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that I took charge of the remains described above, held an <b>PARTIAL AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                                  |   |   |   |   |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b> M.D.  |                                  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/> |   | 23C. DATE SIGNED<br><b>7-19-53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 24B. DATE<br><b>July 21, 53</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood</b>                              |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Greenwood W. Va.</b>  |                                  | 25. FUNERAL DIRECTOR<br><b>Wayne C. Spiggle</b>   |   | ADDRESS<br><b>Davis, W. Va.</b>   |   |



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53 6531

## BALTIMORE CITY HEALTH DEPARTMENT

53 6531

TH NO.

## CERTIFICATE OF DEATH

Registered No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| NAME OF DECEASED<br>(Last name or Print)  |  | Baby Mole   |  | Maxwell   |  | 2. DATE OF DEATH<br>July 10, 1953                            |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland |  | B. COUNTY<br>A.A.-Co.   |  |  |  |
| FULL NAME OF DECEASED<br>(If not in hospital or institution, give street address or location)<br>Doctors Hospital   |  | C. CITY OR TOWN<br>Baltimore 25   |  | D. STREET ADDRESS (If rural, give location)<br>5008 Brookwood Rd 5250       |  |  |  |
| Length of stay in Baltimore<br>1/2 hr   |  | Yrs.<br>Mos.<br>Days  |  | 8. DATE OF BIRTH<br>July 19, 1953   |  | 9. AGE (In years last birthday)<br>Months: Days: Hours: Min. |  |
| SEX<br>Male   |  | 6. COLOR OR RACE<br>White   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>single                   |  | 11. BIRTHPLACE (State or foreign country)                    |  |
| USUAL OCCUPATION (Give kind of one during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A                                     |  |  |  |
| FATHER'S NAME<br>Frank M Maxwell  |  | 14. MOTHER'S MAIDEN NAME<br>Teresa Pauline Koko   |  | 17. INFORMANT<br>Chart of Mother  |  | ADDRESS  |  |
| WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Chart of Mother  |  | ADDRESS  |  |
| 8. 761.5  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                            |  | (A) 1. Infarction of Placenta - Premature Separation of Placenta  |  |   |  |  |  |
| ANTECEDENT CAUSES   |  | (B) Prematurity   |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (C) 6 lbs. 1 oz.  |  |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |   |  |  |  |
| 9A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                      |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from July 10, 1953, to July 10, 1953, that I last saw the deceased alive on July 10, 1953, and that death occurred at m., from the causes and on the date stated above. |  | 23A. SIGNATURE<br>Israel Rosen  |  | 23B. ADDRESS<br>2413 E. Monument St   |  | 23C. DATE SIGNED   |  |
| 24. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                |  |
| RECEIVED BY<br>AL REGISTRAR   |  | REGISTRAR'S SIGNATURE<br>John H. Williams, Jr.  |  | FUNDAL DIRECTOR<br>John H. Williams, Jr.                                    |  | ADDRESS  |  |
| VS 150  |  |   |  |   |  |  |  |





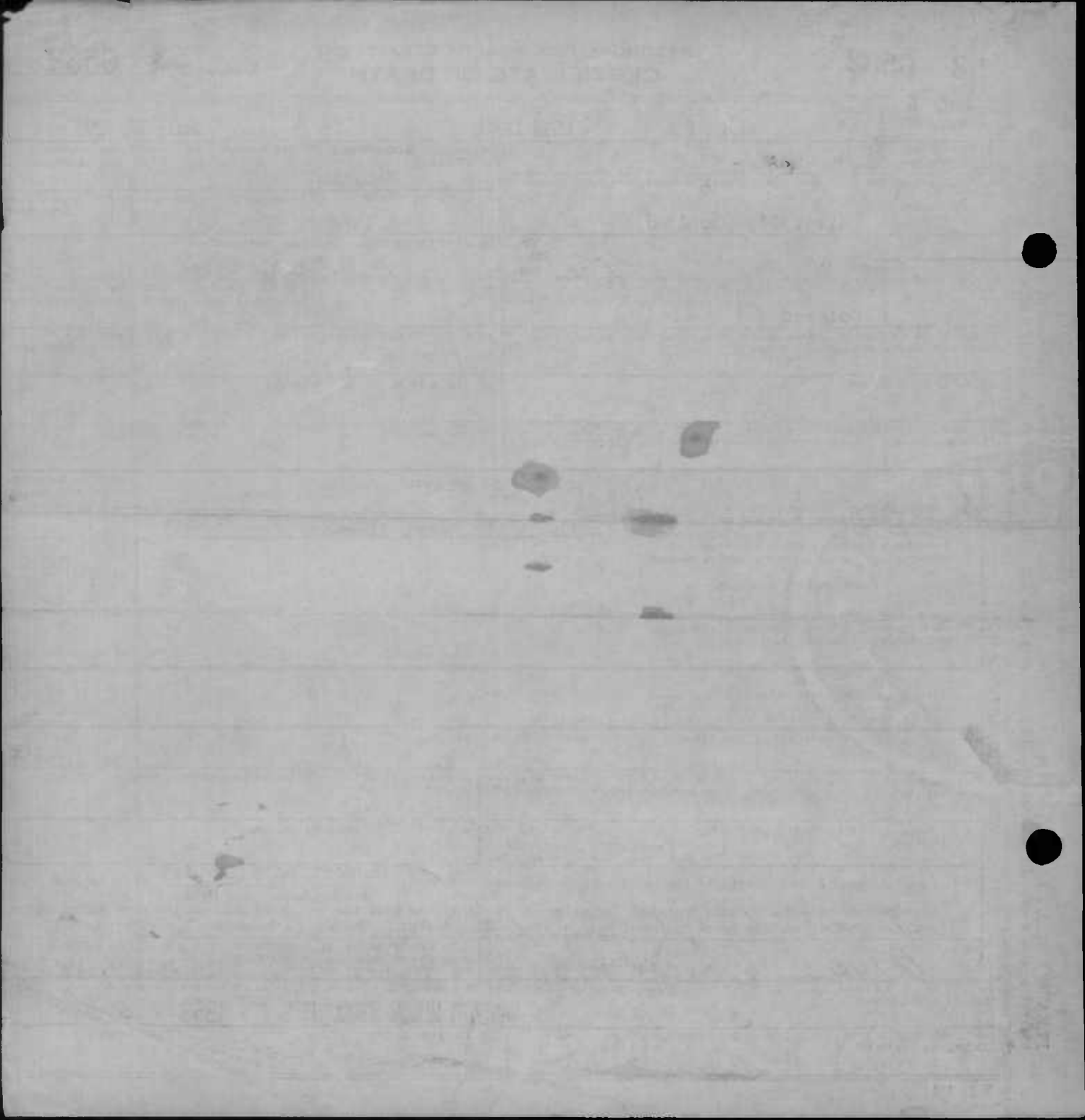
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6532W-452  
53 6532  
BIRTH NO.

|  |                                    |   |  |   |   |
|--|------------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALBERT WILLIAMS</b>  |                                    |   | 2. DATE OF DEATH <b>July 8, 1953</b>   |   |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>                                    |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 17-01</b>                         |   |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>508 W. Biddle Street</b>   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>U</b> | 8. DATE OF BIRTH<br><b>U</b>   | 9. AGE (In years last birthday)<br><b>45?</b> | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>K</b>               | 11. BIRTHPLACE (State or foreign country)<br><b>K</b>  |   | 12. CITIZEN OF WHAT COUNTRY?                                  |
| 13. FATHER'S NAME<br><b>N O</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>O</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                    | 16. SOCIAL SECURITY NO.<br><b>N</b>                         | 17. INFORMANT ADDRESS <input checked="" type="checkbox"/>  |   |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>416x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Rheumatic heart disease</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO<br><b>(C)</b>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>inspection &amp; inquiry</u> thereon and from <u>Autopsy, Inspection or Inquiry</u> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><i>William J. [Signature]</i>   |  | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....  |  | 23C. DATE SIGNED<br><b>July 9, 1953</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
|   |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>UNIVERSITY MEDICAL SCHOOL JUL 17 1953</b> |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>1 9 1953</b> |  | REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  | 25. FUNERAL DIRECTOR ADDRESS<br><i>W. J. Williams, M.D.</i> |  |
| VS 151  |  |   |  |   |  |



53 6533

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6533  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK V. CARUSO

2. DATE  
OF  
DEATH

JULY 17, 53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

MERCY HOSPITAL INC

C. Length of stay in Baltimore

ABOUT 53

YRS.

Mos.

Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

B. COUNTY

BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

26-11

D. STREET ADDRESS (If rural, give location)

3305 FLEET ST

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

BETH STEEL CO.

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF

WHAT COUNTRY?

unknown U.S.

13. FATHER'S NAME

unknown CARUSO.

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

213-753971

17. INFORMANT

FRANCIS CARUSO

ADDRESS

as above

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

6 hrs.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCTION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ACUTE MYOCARDIAL INFARCTION

DUE TO

CORONARY THROMBOSES

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from JULY 17, 1953, to JULY 17, 1953, that I last saw the deceased alive on JULY 17, 1953, and that death occurred at 7:12 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL  
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

6903A

MEDICAL CERTIFICATION

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

|                   |  |                |  |                     |  |                  |  |                 |  |                |  |
|-------------------|--|----------------|--|---------------------|--|------------------|--|-----------------|--|----------------|--|
| NAME OF DECEASED  |  | AGE            |  | SEX                 |  | RACE             |  | DATE OF BIRTH   |  | PLACE OF BIRTH |  |
| JAMES H. HARRIS   |  | 45             |  | M                   |  | W                |  | JAN 15 1880     |  | NEW YORK CITY  |  |
| RESIDENCE         |  | OCCUPATION     |  | CAUSE OF DEATH      |  | MANNER OF DEATH  |  | DATE OF DEATH   |  | PLACE OF DEATH |  |
| 1234 FIFTH AVENUE |  | CLERK          |  | HEART DISEASE       |  | NATURAL          |  | JAN 20 1925     |  | NEW YORK CITY  |  |
| FATHER            |  | MOTHER         |  | SPOUSE              |  | CHILDREN         |  | EDUCATION       |  | RELIGION       |  |
| JOHN H. HARRIS    |  | MARY H. HARRIS |  | ELIZABETH H. HARRIS |  | THOMAS H. HARRIS |  | HIGH SCHOOL     |  | METHODIST      |  |
| BORN              |  | DIED           |  | BURIED              |  | INTERVIEWED      |  | SIGNATURE       |  | OFFICIAL       |  |
| JAN 15 1880       |  | JAN 20 1925    |  | JAN 20 1925         |  | JAN 20 1925      |  | JAMES H. HARRIS |  | JOHN J. HARRIS |  |

53 6534

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6534  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hosa C. Lenthicum

2. DATE  
OF  
DEATH

7-19-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3026 Garrison Blvd

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Aug 17 - 1869

9. AGE (In years  
last birthday)

85

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Wheeler

14. MOTHER'S MAIDEN NAME

Cordelia Crew

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

May C. Lenthicum 3026 Garrison Blvd

18. 443X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cardio Vascular Disease

INTERVAL BETWEEN  
ONSET AND DEATH

3-4-1-1

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio Sclerosis Advanced

7

(C) DUE TO

Hypertension

7

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to July 19, 1953 that I last saw the  
deceased alive on July 19, 1953, and that death occurred at 7 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Haller S. Tullitt

23B. ADDRESS

7220 Garrison Blvd

23C. DATE SIGNED

July 19/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-19-53

24C. NAME OF CEMETERY OR CREMATORY

Cedar Bluff

24D. LOCATION (City, town, or county) (State)

Annapolis A.D. Md

25. FUNERAL DIRECTOR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John M. Taylor - Son

Annapolis Md.

VS 150 1953

8234

8234

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



- 400

53 6535

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6535

Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print)

Seawell, Charles. C.

2. DATE  
OF  
DEATH

7. 18. 1953.

PLACE OF DEATH:

Baltimore City, Maryland

Baltimore Md.

FULL NAME OF (If not in hospital or institution, give street address or location)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1005 N. Calvert St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)

Executive

10a. KIND OF BUSINESS OR INDUSTRY

Board of Internal Revenue

FATHER'S NAME

Roy Seawell

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

4/16/1881

9. AGE (In years last birthday)

72

If Under 1 Year Months; Days If Under 24 Hours Hours; Min.

11. BIRTHPLACE (State or foreign country)

Moore Co N.C.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Matter Johnson

17. INFORMANT

Margaret Seawell Calvert St.

18. 491X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Shock

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Purulent Bronchopneumonia

DUE TO

(C) Circulatory failure

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7. 13. 1953, to 7. 18. 1953, that I last saw the deceased alive on 7. 18. 1953, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Morris Goldberg

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

7. 18. 53

A. BURIAL, CREMATION, REMOVAL

24B. DATE

7-19-53

24C. NAME OF CEMETERY OR CREMATORY

Ashville

24D. LOCATION (City, town, or county)

N.C.

(State)

TE RECEIVED BY CAL REGISTRAR

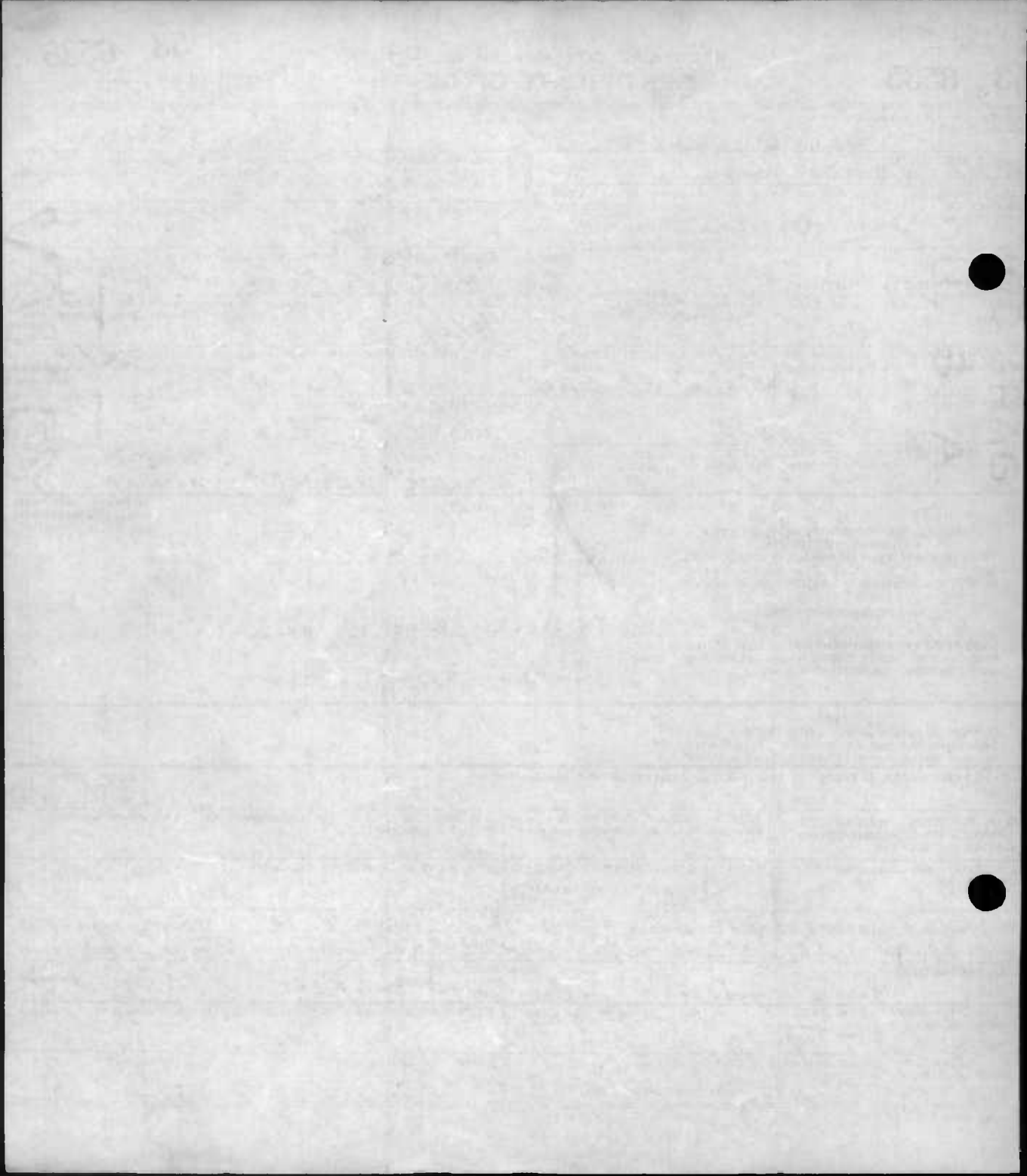
REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Cook, Inc. 1217 St. Paul St.



|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 145   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 53  |  | 6536  |  |
| 6536  |  | CERTIFICATE OF DEATH  |  | Registered No.  |  |   |  |
| NAME OF DECEASED<br>(Last, first, middle, or Print)   |  | 2. DATE OF DEATH  |  | July 17, 1953   |  |   |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)   |  | A. STATE<br>Maryland  |  | B. COUNTY<br>19-02  |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>Aged Women's Home   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  |  | Baltimore   |  |   |  |
| D. STREET ADDRESS (If rural, give location)<br>1400 N. Lexington Street   |  | E. LENGTH OF STAY IN BALTIMORE  |  | Yrs.<br>Mos.<br>Days  |  |   |  |
| F. SEX<br>Male  |  | G. COLOR OR RACE<br>White   |  | H. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single                           |  | I. DATE OF BIRTH<br>July 26, 1873   |  |
| J. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br>Unknown   |  | K. KIND OF BUSINESS OR INDUSTRY<br>-  |  | L. BIRTHPLACE (State or foreign country)<br>Germany                                 |  | M. AGE (In years last birthday)<br>79   |  |
| N. FATHER'S NAME<br>Herman Henry Labeling   |  | O. MOTHER'S MAIDEN NAME<br>Maria Elizabeth Handrup  |  | P. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | Q. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>no or unknown |  |
| R. SOCIAL SECURITY NO.<br>215-2460207   |  | S. INFORMANT<br>L. H. Read  |  | T. ADDRESS<br>1400 N. Lexington St.   |  |   |  |
| U. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive Cardiovascular Disease |  | V. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | W. INTERVAL BETWEEN ONSET AND DEATH<br>?  |  |   |  |
| X. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |   |  |   |  |
| Y. DATE OF OPERATION<br>0   |  | Z. MAJOR FINDINGS OF OPERATION  |  | AA. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| AB. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  |  | AC. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | AD. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |   |  |
| AE. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | AF. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                             |  | AG. HOW DID INJURY OCCUR?   |  |   |  |
| AH. I hereby certify that I attended the deceased from July 16, 1953, to July 17, 1953, that I last saw the deceased alive on July 16, 1953, and that death occurred at 9 A. M., from the causes and on the date stated above.            |  |   |  |   |  |   |  |
| AI. SIGNATURE<br>Alfred S. Nelson   |  | AJ. ADDRESS<br>Baltimore, Maryland  |  | AK. DATE SIGNED<br>July 17, 1953  |  |   |  |
| AL. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | AM. DATE<br>7/20/53   |  | AN. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                              |  | AO. LOCATION (City, town, or county) (State)<br>Woodlawn, Maryland                                  |  |
| AP. RECEIVED BY<br>Huntington Williams, M.D.  |  | AQ. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  | AR. FUNERAL DIRECTOR<br>Wm. Cook, Inc.  |  | AS. ADDRESS<br>1217 E. Paul St.   |  |
| VS 150  |  |   |  |   |  |   |  |



520

3 6537

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6537

NAME OF DECEASED  
(Please Print)

NORMAN, F JONES

2. DATE  
OF  
DEATH

July 17, 1953

PLACE OF DEATH:

Baltimore City, Maryland 3501 Woodland Ave

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3105 Woodland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-16

D. STREET ADDRESS (If rural, give location)

3105 Woodland Avenue

Length of stay in Baltimore

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 5, 1902

9. AGE (In years,  
last birthday)

50

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.1. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Fire Dept

10B. KIND OF BUSINESS OR  
INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

St. Marys Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

FATHER'S NAME

William Jones

14. MOTHER'S MAIDEN NAME

Ethel Bassford

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-26-4272

17. INFORMANT

Mrs. J. A. Jones

ADDRESS

3105 Woodland Ave.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) CORONARY OCCLUSION

DUE TO

30 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) CORONARY THROMBOSIS

DUE TO

6 weeks

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Hypertensive Heart disease, decompensating

10 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 29, 1953, to July 17, 1953, that I last saw the deceased alive on July 17, 1953, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Randolph H. Spitzberg

23B. ADDRESS

5010 Denmore Ave

23C. DATE SIGNED

July 18, 1953

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 20, 1953

24C. NAME OF CEMETERY OR CREMATORY

Trinity Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Maryland

25. RECEIVED BY  
LOCAL REGISTRAR

10-1953

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

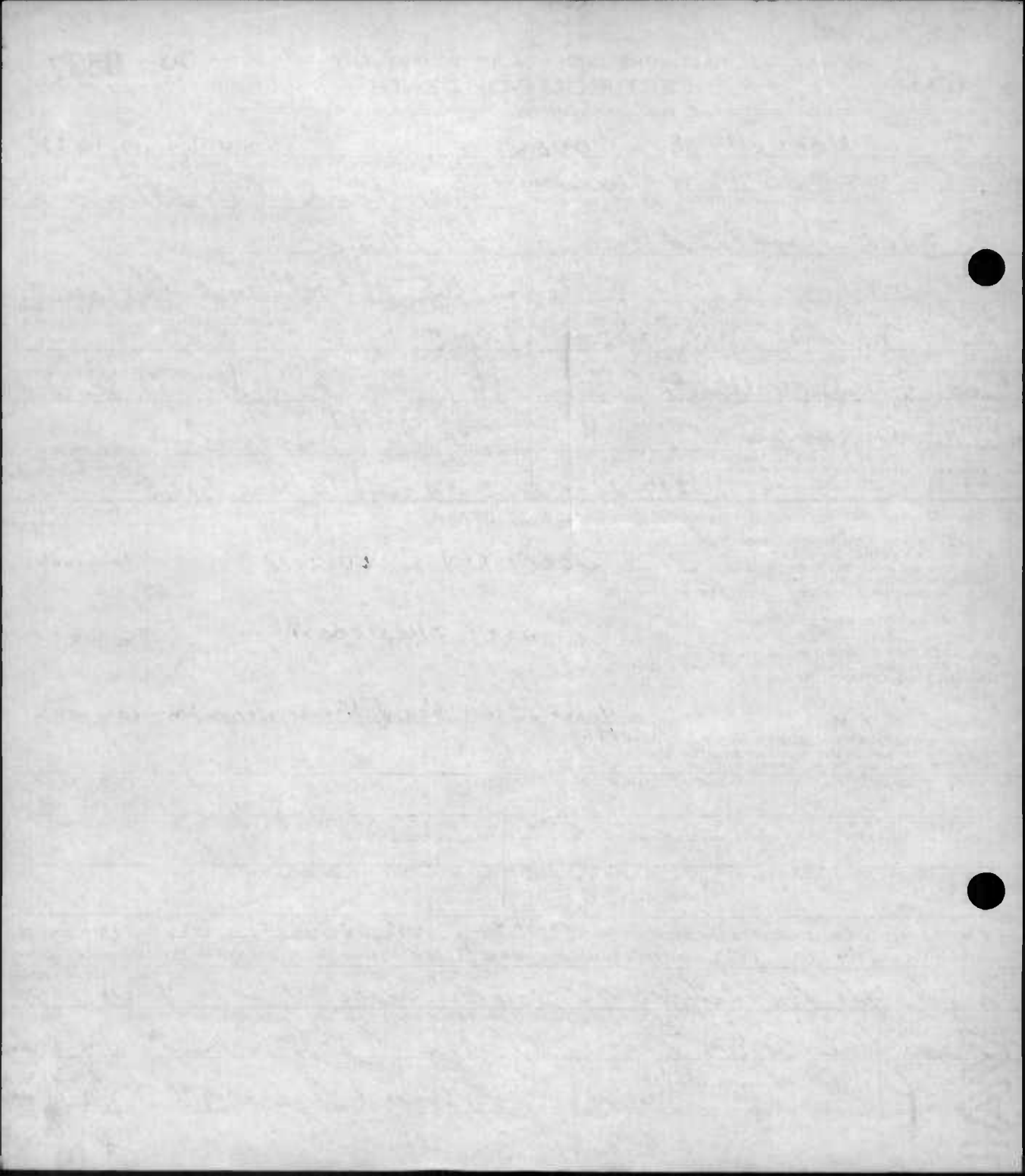
25. FUNERAL DIRECTOR

Loring Byers

ADDRESS

5005 W. 7th Ave.

762 93





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-560

53 6538

# HEINER

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                                    |   |  |   |   |
|---|------------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Helena Fannie Heiner</i>  |                                    |   | 2. DATE OF DEATH<br><i>July 16, 1953</i>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY _____ |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>2313 M<sup>rs</sup> Cullah St.</i>                              |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 13-03</i>                               |   |   |
| 6. Length of stay in Baltimore <i>53 yrs.</i>   |                                    |   | D. STREET ADDRESS (If rural, give location)<br><i>2313 M<sup>rs</sup> Cullah St.</i>   |   |   |
| 7. SEX<br><i>Female</i>   | 8. COLOR OR RACE<br><i>Colored</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 10. DATE OF BIRTH<br><i>Jan. 29, 1901</i>  | 11. AGE (In years last birthday)<br><i>53</i> | 12. If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Teacher</i> |                                    |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Public School</i>  |   |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i>  |                                    |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |   |   |
| 13. FATHER'S NAME<br><i>Benjamin Connor</i>   |                                    |   | 14. MOTHER'S MAIDEN NAME<br><i>Kellie Perry</i>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)      |                                    |   | 16. SOCIAL SECURITY NO.<br><i>Mr. Bernard O. Heiner</i><br><i>2313 M<sup>rs</sup> Cullah St.</i>                                     |   |   |

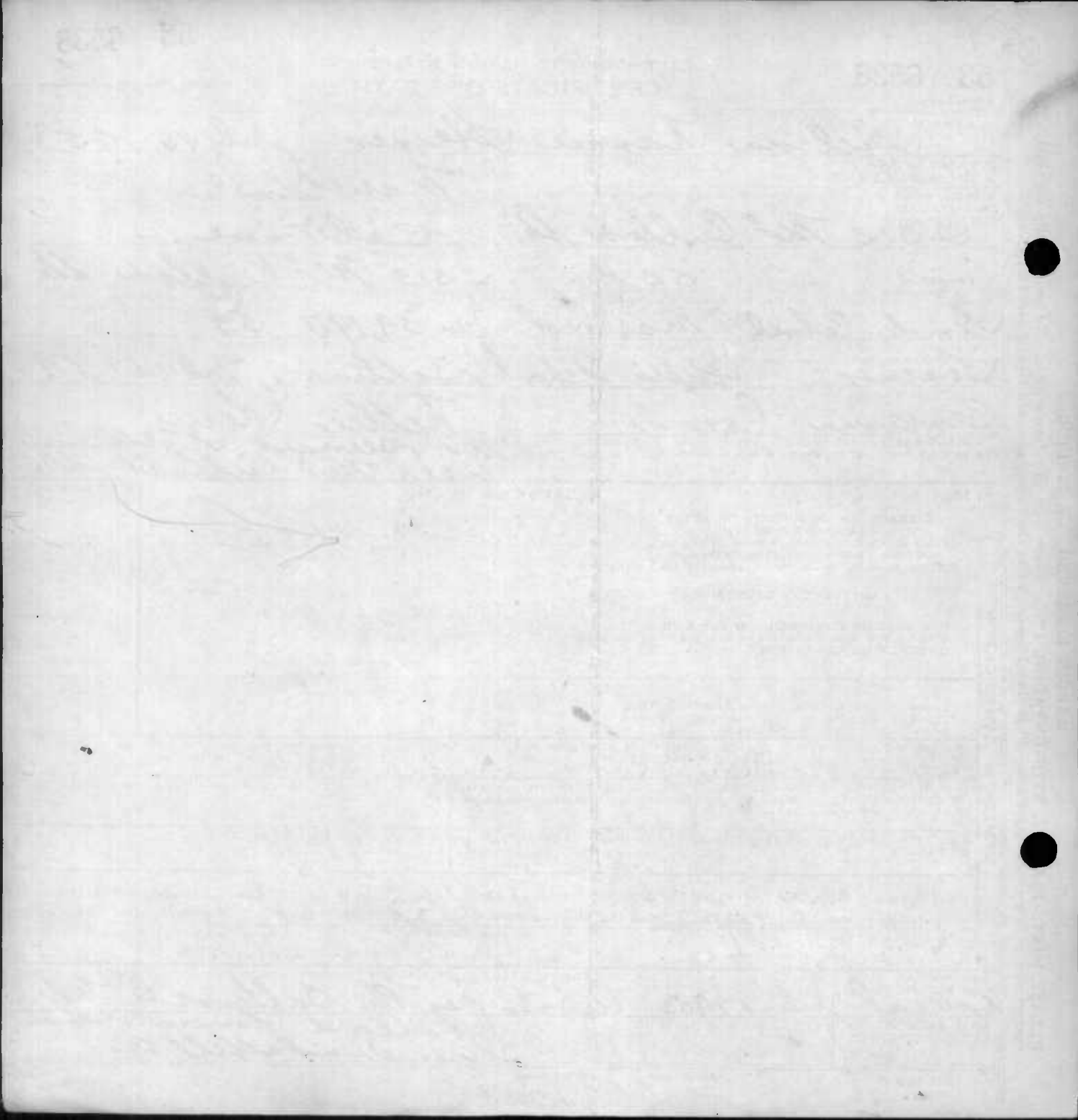
|   |   |   |
|---|---|---|
| 18. <i>153X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Carcinomatosis</i> | CAUSE OF DEATH<br>(A) <i>Carcinomatosis</i><br>DUE TO | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 mos.</i> |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Coreioma of Sigmoid Colon</i>  | (B) <i>Coreioma of Sigmoid Colon</i><br>DUE TO        | (C) <i>Jan '53</i>                                |

|   |   |  |   |
|---|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                    |   |  |   |
| 19A. DATE OF OPERATION<br><i>April 1953</i>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Ca. of Colon - Obstruction</i>                     | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

|   |   |  |   |
|---|---|--|---|
| 22. I hereby certify that I attended the deceased from <i>January, 1953</i> , to <i>July, 1953</i> , that I last saw the deceased alive on <i>July 16, 1953</i> , and that death occurred at <i>6 P. m.</i> , from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><i>J. B. Snow</i>   | 23B. ADDRESS<br><i>2243 Madison Ave</i>             | 23C. DATE SIGNED<br><i>7-19-53</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE<br><i>July 20, 1953</i>                   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Arbiter Mem. Pk.</i>                      | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Co. Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 20 1953</i>  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i> | 5. FUNERAL DIRECTOR<br><i>Wallace Funeral Home</i><br><i>1651 Daniel Hill Ave.</i> |   |

VS 150

0938V



53 6539

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6539  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLYDE REED WINSTON

2. DATE  
OF  
DEATH

July 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-01

D. STREET ADDRESS (If rural, give location)

1812 W. Franklin Street

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 22, 1925

9. AGE (In years

last birthday)

20

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Taxi Cab

11. BIRTHPLACE (State or foreign country)

Keyserville, Va

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John H. Winston

14. MOTHER'S MAIDEN NAME

Mary Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

W II

16. SOCIAL SECURITY NO.

234-36-3242

Keyserville, Va

1812 W. Franklin St

18. E982X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple stab wounds

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Laceration of branch of left pulmonary

artery

(C) Hemothorax, left

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3500 block of Wright Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 17, 1953 2:00 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Instrument

Attacked and stabbed with sharp

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

Joseph G. Jackson

23B. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

MEDICAL INVESTIGATOR

23C. DATE SIGNED

July 17, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial July 21, 1953

24B. DATE

July 21, 1953

24C. NAME OF CEMETERY OR CREMATORY

Family Lot

24D. LOCATION (City, town or county)

Keyserville, Va

DATE RECEIVED BY LOCAL REGISTRAR

July 20, 1953

REGISTRAR'S SIGNATURE

Huntington Williams

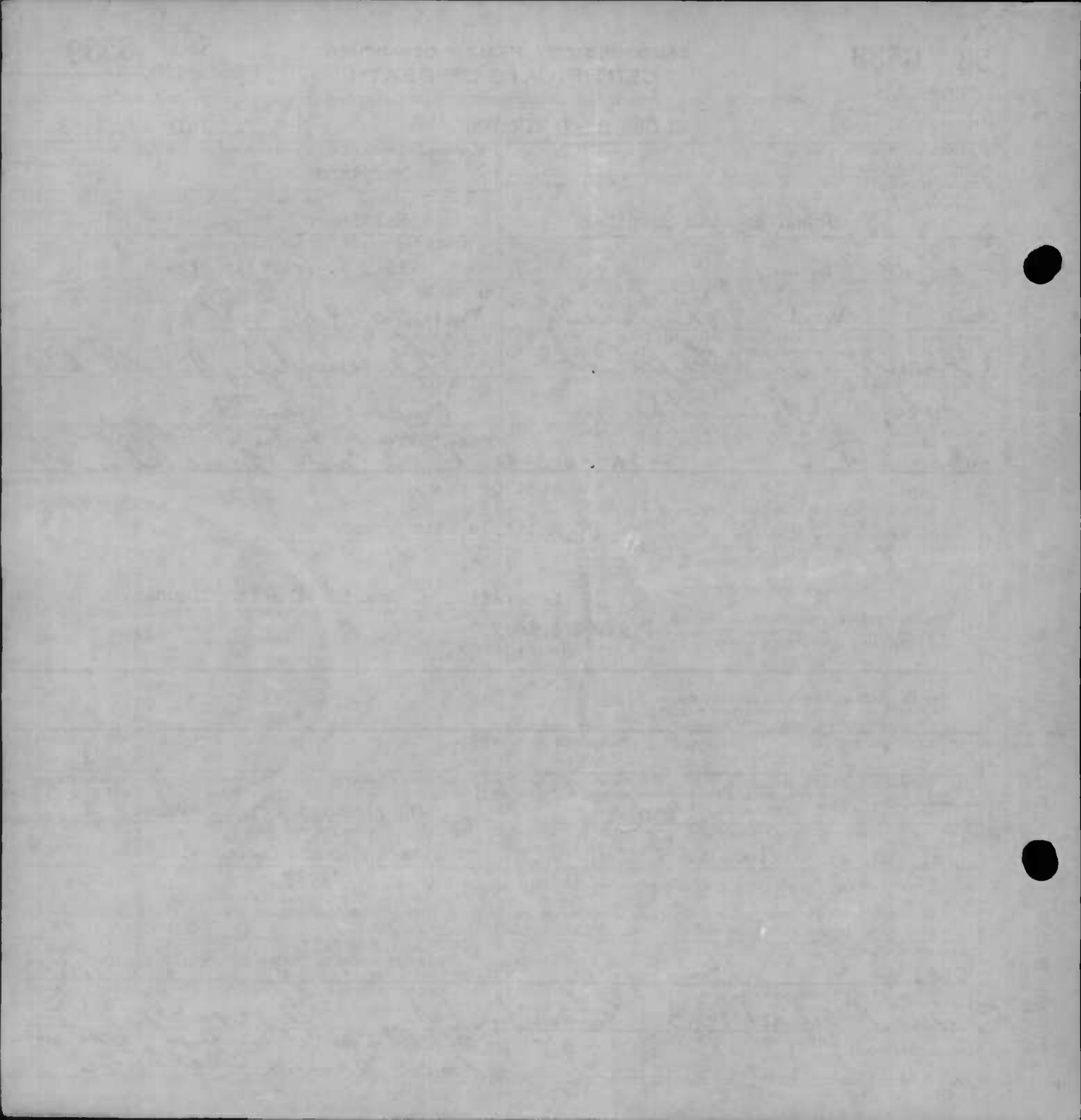
15. SIGNER'S ADDRESS

165 W. Druid Hill Ave

VS 151

N 860.2

68254



5-323

6540

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

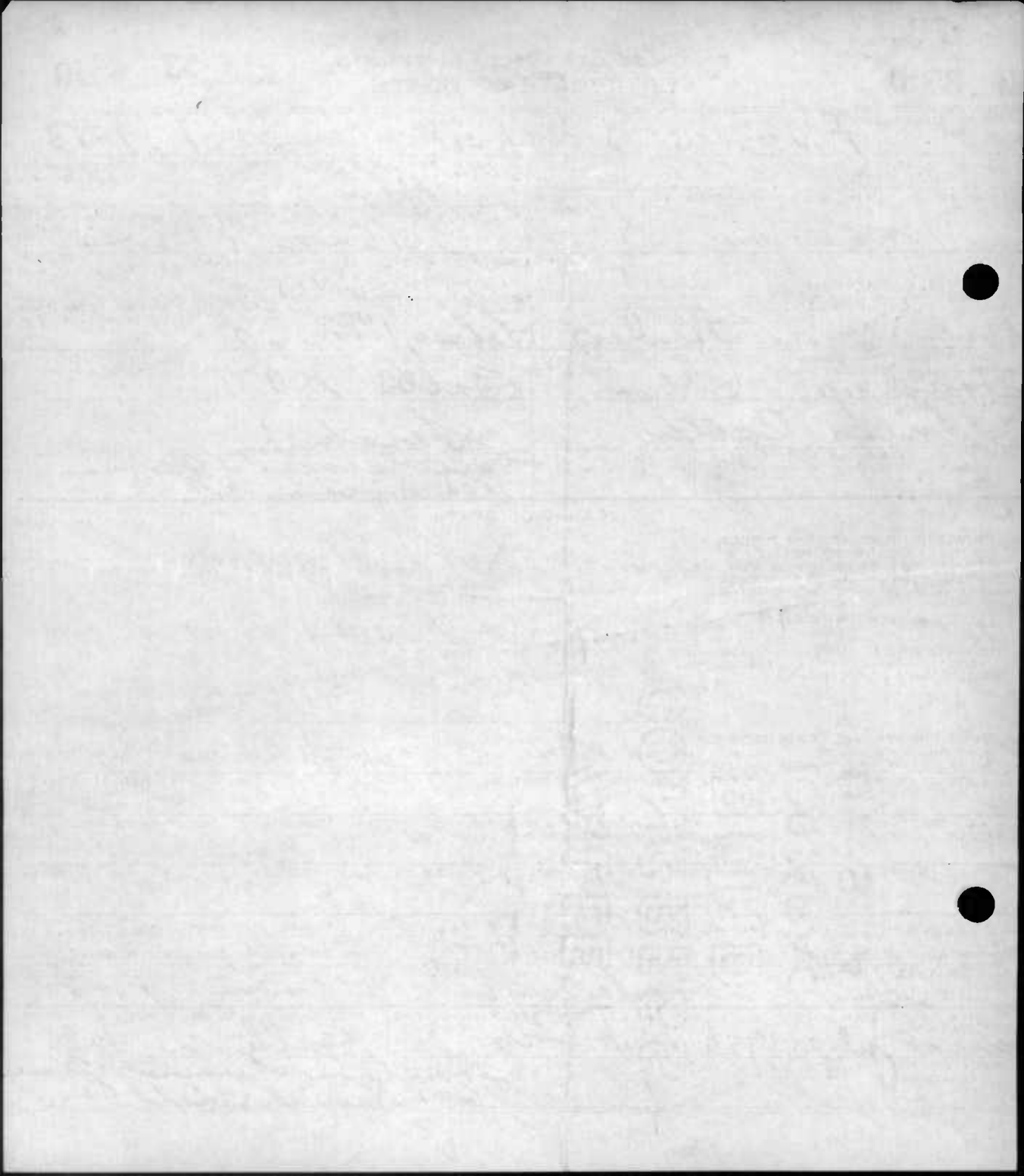
Registered No. 53 6540

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>(Please Print) <b>Frances Stockett</b>   |  | 2. DATE OF DEATH <b>7-17-53</b>  |  |
| PLACE OF DEATH: <b>Baltimore City, Maryland</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Ma.</b> B. COUNTY |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>1804 Division St.</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 14-03</b>                 |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1804 Division St.</b>  |  | E. DATE OF BIRTH <b>Feb 20, 1886</b>   |  |
| F. AGE (in years last birthday) <b>67</b>  |  | G. AGE (in years last birthday) <b>67</b>  |  |
| H. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Housewife</b>               |  | I. BIRTHPLACE (State or foreign country)<br><b>Baldu Md.</b>   |  |
| J. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | K. CITIZEN OF WHAT COUNTRY?  |  |
| L. FATHER'S NAME<br><b>Thomas Carter</b>   |  | M. MOTHER'S MAIDEN NAME<br><b>Sarah ?</b>  |  |
| N. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                                     |  | O. SOCIAL SECURITY NO.   |  |
| P. INFORMANT<br><b>Miss Grace Spence</b>   |  | Q. ADDRESS<br><b>1804 Division St.</b>   |  |

|  |  |  |  |
|--|--|--|--|
| R. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b> |  | S. INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |  |
| T. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Essential Hypertension &amp; Arteriosclerosis</b>  |  |  |  |
| U. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Chronic Bronchial Asthma</b>  |  | <b>2 yrs.</b>  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| V. DATE OF OPERATION <b>0</b>                  |  | W. MAJOR FINDINGS OF OPERATION   |  | X. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| Y. ACCIDENT, SUICIDE, HOMICIDE (Specify)       |  | Z. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                  |  | AA. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| AB. TIME (Month) (Day) (Year) (Hour) OF INJURY |  | AC. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | AD. HOW DID INJURY OCCUR?   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| AE. I hereby certify that I attended the deceased from <b>July 15, 1953</b> , to <b>July 17, 1953</b> , that I last saw the deceased alive on <b>July 17, 1953</b> , and that death occurred at <b>7:50 p. m.</b> , from the causes and on the date stated above. |  |   |  |  |  |
| AF. SIGNATURE<br><b>Gilbert L. Bonfield</b>   |  | AG. ADDRESS<br><b>222 N. Fulton Ave</b>             |  | AH. DATE SIGNED<br><b>7/17/53</b>                                    |  |
| AI. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial July 21, 1953</b>   |  | AJ. NAME OF CEMETERY OR CREMATORY<br><b>Wm. Zim</b> |  | AK. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md</b> |  |
| AL. RECEIVED BY REGISTRAR<br><b>20 1953</b>   |  | AM. REGISTRAR'S SIGNATURE<br><b>Huntington</b>      |  | AN. FUNERAL DIRECTOR<br><b>1631 Daniel Hill Ave</b>                  |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered **53** **6541**BIRTH NO. **53 6541**

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lillie M. Pfeiffer</b>                            |                                  |   | 2. DATE OF DEATH<br><b>7-18-53</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>8-04</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2325 East Preston Street</b>                  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |   |
| c. Length of stay in Baltimore <b>Life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>2325 East Preston Street</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>Dec. 1 1870</b>   | 9. AGE (In years last birthday)<br><b>82</b> | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>               | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>               |
| 13. FATHER'S NAME<br><b>John C. Schwarz</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Fredericka Bauer</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                           |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Frederick H. Pfeiffer - 2325 E. Preston St.</b>  |  |   |

|   |   |  |
|---|---|--|
| 18. <b>442X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive Cardio-Renal vascular disease</b> | CAUSE OF DEATH<br>(A) <b>Hypertensive Cardio-Renal vascular disease</b><br>DUE TO<br>(B) <b>Arteriosclerosis</b><br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 y. +</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   |  |

## II OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION <b>0</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **Dec. 1, 1948** to **July 18, 1953**, that I last saw the deceased alive on **7-18, 1953**, and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23A. SIGNATURE<br><b>David Schneider</b>                   | M. D.                       | 23B. ADDRESS<br><b>1101 N. Winton Ave</b>                | 23C. DATE SIGNED<br><b>7-18-53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-21-53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>North Ave. - Balto. Md.</b> |

|  |   |   |
|--|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 20 1953</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>John C. Miller Inc. - 2431 E. Oliver St.</b> |
|--|---|---|

7-11-7

MEMO TO THE DIRECTOR, FBI, FROM THE SAC, NEW YORK, DATED 7-11-7, RE: [illegible]

RE: [illegible]

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

R-360  
53 6542BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6542

BIRTH NO.

|   |                                  |   |   |  |                                  |
|---|----------------------------------|---|---|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Jennie M. Roeder</i>  |                                  |   | 2. DATE OF DEATH<br><i>7-17-53</i>  |  |                                  |
| 3. PLACE OF DEATH<br>a. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY |  |                                  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>342 South Lehigh Street</i>                                       |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 26-07</i>                      |  |                                  |
| c. Length of stay in Baltimore <i>Life</i>  |                                  |   | d. STREET ADDRESS (If rural, give location)<br><i>342 South Lehigh Street</i>   |  |                                  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i> | 8. DATE OF BIRTH<br><i>May 9, 1877</i>  | 9. AGE (In years last birthday)<br><i>76</i> | 10. Under 1 Year<br>Months: Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>   |  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Balto. - Md.</i>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  |                                  |
| 13. FATHER'S NAME<br><i>George Ditmayer</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Marie T. Manner</i>  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                  |   | 16. SOCIAL SECURITY NO.<br><i>220-01-6006</i>   |  |                                  |
| 17. INFORMANT<br><i>George J. Kissner</i>   |                                  |   | ADDRESS<br><i>342 S. Lehigh St.</i>   |  |                                  |

|   |                                 |                                  |
|---|---------------------------------|----------------------------------|
| 18. <i>443X</i>   | CAUSE OF DEATH                  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Cerebral Hemorrhage</i>  |                                  |
| ANTECEDENT CAUSES   | (B) <i>Hypertension</i>         |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C) <i>Chronic Hypertension</i> |                                  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><i>0</i>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from *7/17*, 19*53*, to *7/17*, 19*53* that I last saw the deceased alive on *7/17*, 19*53*, and that death occurred at *m.*, from the causes and on the date stated above.

23A. SIGNATURE *Joseph Tanbury* 23B. ADDRESS *4418 Seaboard Ave* 23C. DATE SIGNED *7/18/53*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *7-20-53* 24C. NAME OF CEMETERY OR CREMATORY *Mount Carmel Cem.* 24D. LOCATION (City, town, or county) (State) *O'Donnell St. - Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR *Jul 20 1953* REGISTRAR'S SIGNATURE *John C. Miller Inc.* 25. FUNERAL DIRECTOR ADDRESS *2431 E. Chesa St.*



255

3 6543

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6543

TH NO.

NAME OF DECEASED  
(or Print)

Rebecca Fuxman

2. DATE  
OF  
DEATH

2/18/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
CLINIC

Mercy Hospital Inc

Length of stay in Baltimore

53

Yrs.  
Mos.  
Days

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

FATHER'S NAME

(not known) Jacob Wolfe

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Jake Fuxman - 2003 N. Pulaski St

8. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Vascular Accident

6 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cerebrovascular Disease

3 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/18 7 PM, 1953, to 2/18 10:45 PM, 1953, that I last saw the  
deceased alive on 2/18, 1953, and that death occurred at 10:45 PM., from the causes and on the date stated above.

23A. SIGNATURE

G. J. Wallin

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

2/18/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

2/20/53

24C. NAME OF CEMETERY OR CREMATORY

Tiferes Israel

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

E RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hall

25. FUNERAL DIRECTOR

Sol. Levinson &amp; Bros - 1124-26 W.

ADDRESS

North Avenue

VS 150





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6544  
Registered No.

TH NO.

NAME OF DECEASED  
(Name or Print)

William M. Kram

2. DATE  
OF  
DEATH July 18, 1953

PLACE OF DEATH:

Baltimore City, Maryland Baltimore

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2354 Sidney Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 25-33

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
2354 Sidney Ave.

Length of stay in Baltimore Life  
Yrs. Mos. Days

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov 22, 1882 9. AGE (In years last birthday) 70 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) Retired 10a. KIND OF BUSINESS OR INDUSTRY Gunther Brewery

11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

John Fram

14. MOTHER'S MAIDEN NAME

Wilhelmina ?

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No or unknown

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Threesa Fram 2354 Sidney Ave

8. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) HYPERTENSIVE CARDIOVASCULAR DISEASE 5 YRS 8

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CEREBRAL HEMORRHAGE E. RIGHT SIDE PARALYSIS 2 YRS 10 MOS

9A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from SEPT 25, 1950, to JULY 18, 1953, that I last saw the deceased alive on JULY 8, 1953, and that death occurred at 8:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

BURIAL, CREMA- REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial July 21, 1953 Holy Redeemer

Baltimore, Md.

RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

201501 201553 H. J. G. W. M. P. Lilly & Zeiler Inc., 403 S. Wolfe St.

69046

422 82

RECEIVED

CERTIFICATE OF DEATH

1911

1912

1913

1914

1915

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1922

1923

1924

1925

1926

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1932

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1940

| 263<br>6545  |                              | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 53 6545<br>Registered No.   |   |
|--|------------------------------|---|--|---|---|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><b>AMELIA ECKERT</b>  |                              |   | 2. DATE OF DEATH<br><b>July 17, 1953</b>   |   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>607 S. Port Street</b>   |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |   |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>Life</b>  |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>607 S. Port Street</b>   |   |   |
| 7. SEX<br><b>W</b>   | 8. COLOR OR RACE<br><b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>                                       | 10. DATE OF BIRTH<br><b>Sept. 6, 1862</b>  | 11. AGE (in years last birthday)<br><b>90</b>                                       | 12. UNDER 1 Year Months: Days<br>Under 24 Hours Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Housework</b>  |                              |   | 14. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |   |   |
| 15. FATHER'S NAME<br><b>Louis Burgert</b>  |                              |   | 16. MOTHER'S MAIDEN NAME<br><b>?</b>   |   |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)<br><b>none</b>  |                              |   | 18. SOCIAL SECURITY NO.<br><b>none</b>   |   |   |
| 19. INFORMANT<br><b>Robert J. Eckert</b>   |                              |   | 20. ADDRESS<br><b>607 S. Port Street</b>   |   |   |
| 21. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia</b><br>DUE TO<br>(A)<br>II<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>arteriosclerotic C. V. D.</b><br>DUE TO<br>(B)<br>(C) |                              |   | 22. INTERVAL BETWEEN ONSET AND DEATH<br><b>6 day</b><br><b>20 yrs.</b>   |   |   |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                              |   |  |   |   |
| 24. DATE OF OPERATION<br><b>0</b>  |                              | 25. MAJOR FINDINGS OF OPERATION   |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                              | 28. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |   |
| 30. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                              | 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 32. HOW DID INJURY OCCUR?   |   |
| 33. I hereby certify that I attended the deceased from <b>6/6, 1953</b> to <b>7/17, 1953</b> that I last saw the deceased alive on <b>7/14, 1953</b> and that death occurred at <b>10 Am.</b> , from the causes and on the date stated above.  |                              |   |  |   |   |
| 34. SIGNATURE<br><b>J. Chapman</b>   |                              | 35. ADDRESS<br><b>1212 N. Patterson St. Baltimore, Md.</b>  |  | 36. DATE SIGNED<br><b>7/18/53</b>   |   |
| 37. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 38. DATE<br><b>7/20/53</b>  |  | 39. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                       |   |
| 40. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |                              | 41. STATE<br><b>Md.</b>   |  | 42. REGISTRAR'S SIGNATURE<br><b>Henry Sander</b>                                    |   |
| 43. RECEIVED BY<br><b>AL REGISTRAR</b>   |                              | 44. FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS, INC.</b>  |  | 45. ADDRESS<br><b>BALTO. 13, MD.</b>  |   |
| VS 150<br><b>George Sander</b>   |                              |   |  |   |   |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

*George Smith*

324

3 6546

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6546

Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

SOPHIA LOUISE PETZOLD

2. DATE  
OF  
DEATH

July 16, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2861 Mayfield Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

3205 Clarence Avenue

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 8, 1889

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.USUAL OCCUPATION (Give kind of  
during most of working life, even if retired)

Sales lady

10B. KIND OF BUSINESS OR  
INDUSTRY

Arcade Theatre

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

William Frederick Hoffman

14. MOTHER'S MAIDEN NAME

Elizabeth Mehrling

HAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.17. INFORMANT 1604 N. Washington Street  
Mr. Wm. Petzold

9. 260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage

2 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertension  
(C) Diabetes mellitus5 years  
8 yearsOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)1D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

none

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from July 14, 1953, to July 16, 1953, that I last saw the  
deceased alive on 7-14, 1953, and that death occurred at 1 P. M., from the causes and on the date stated above.

3A. SIGNATURE

E. J. Gandy

23B. ADDRESS

M. D.

5186 Harford Rd

23C. DATE SIGNED

7-17-53

BURIAL, CREMA-  
REMOVAL (Specify)

burial

24B. DATE

7/27/53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER &amp; SONS, INC.

ADDRESS

BALTO., MD.

VS 150

4908M George Sander

822

FEDERAL BUREAU OF INVESTIGATION  
CENTRAL BUREAU OF DEATH

|                                      |  |  |  |
|--------------------------------------|--|--|--|
| Name of Deceased                     |  | Date of Death                                |  |
| Place of Birth                       |  | Date of Birth                                |  |
| Sex                                  |  | Race   |  |
| Marital Status                       |  | Occupation                                   |  |
| Cause of Death                       |  | Manner of Death                              |  |
| Signature of Physician               |  | Signature of Coroner                         |  |
| Signature of Medical Examiner        |  | Signature of Death Investigator              |  |
| Signature of Funeral Home            |  | Signature of Burial Place                    |  |
| Signature of Next of Kin             |  | Signature of Social Security Office          |  |
| Signature of State Health Department |  | Signature of Federal Bureau of Investigation |  |





PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

53 6547

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6547  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM G. RASCH

2. DATE  
OF  
DEATH

7/17/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore, Md.*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*University Hospital*

38

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Md.* B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore* *27-13*

D. STREET ADDRESS (If rural, give location)

*105 St. Johns Road*

5. SEX

*MALE*

6. COLOR OR RACE

*WHITE*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH

*Feb. 11, 1867*

9. AGE (In years last birthday)

*86*

10 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*retired*

10B. KIND OF BUSINESS OR INDUSTRY  
*Wholesale widow shades*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Gustav A. Rasch*

14. MOTHER'S MAIDEN NAME

*Emma Kennedy*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

*Mr. Gustav A. Rasch 3700 Barrington Road*

ADDRESS

18. *177X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Terminal Carcinoma of Prostate*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Uremic destruction + Uremia*

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/15*, 19*53* to *7/17*, 19*53* that I last saw the deceased alive on *7/17*, 19*53*, and that death occurred at *2:25 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Walter H. Byerly*

23B. ADDRESS

*University Hosp, Balto., Md.*

23C. DATE SIGNED

*7/17/53*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*July 20, 1953*

24C. NAME OF CEMETERY OR CREMATORY

*Druid Ridge*

24D. LOCATION (City, town, or county)

*Pikesville, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*John O. Mitchell Sons*

ADDRESS

*1900 Eutaw Place*

*JUL 20 1953*

VS 150



MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-525

53 6548

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6548

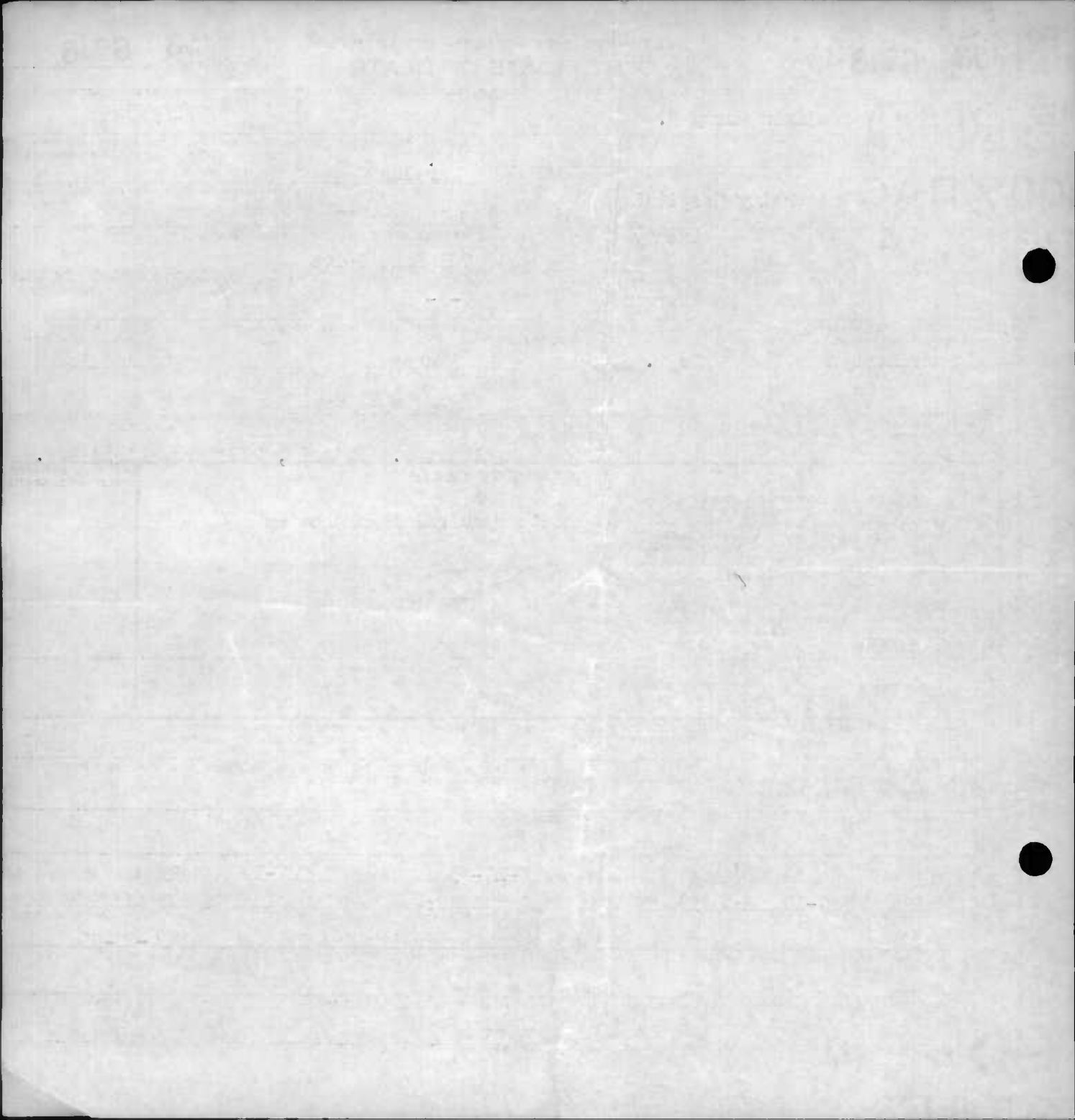
BIRTH NO.

|   |                              |  |                                   |
|---|------------------------------|--|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Benjamin Harry E.</b>   |                              | 2. DATE OF DEATH<br><b>7/19/53</b>   |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                                   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 17 13-01</b>                      |                                   |
| c. Length of stay in Baltimore<br><b>twenty</b> Yrs. Mos. Days  |                              | D. STREET ADDRESS (If rural, give location)<br><b>721 Lake Drive</b>   |                                   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>  | 8. DATE OF BIRTH<br><b>7-5-85</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>merchant</b>        |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Europe</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>American</b>  |                                   |
| 13. FATHER'S NAME<br><b>Wolfe</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Lana Rosenbloom</b>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                              | 16. SOCIAL SECURITY NO.<br><b>X</b>  |                                   |
| 17. INFORMANT<br><b>Albert N. Benjamin</b>  |                              | ADDRESS<br><b>2529 Brookfield Ave.</b>   |                                   |

|  |  |  |
|--|--|--|
| 18. <b>420.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b><br>DUE TO<br><b>arteriosclerotic heart disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 19. <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>7-17-53</b> , 19 <b>53</b> , to <b>7-19-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-19</b> , 19 <b>53</b> , and that death occurred at <b>5:58</b> a. m., from the causes and on the date stated above.                       |  |  |
| 23A. SIGNATURE<br><b>Jose Canino</b>   | 23B. ADDRESS<br><b>University Hospital</b>   | 23C. DATE SIGNED<br><b>7-19-53</b>                                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7-20-1953</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto Helrod</b>                |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>20 1953</b>   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  | 25. FUNERAL DIRECTOR<br><b>Jeff Lewis Inc - 2100 Eutaw Pl.</b>           |

VS 150

2906A



530

6549

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6549  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

William L. Smith

2. DATE  
OF  
DEATH

7/17/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore General Hosp.

Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21-02

D. STREET ADDRESS (If rural, give location)

1216 Sargent St.

SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

9/16/83

9. AGE (In years last birthday)

69

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

Material Distributor

10a. KIND OF BUSINESS OR INDUSTRY

B. &amp; O. R. R.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

George Smith

14. MOTHER'S MAIDEN NAME

Emma Ortel

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Anna Smith, (WIFE) 1216 Sargent St

8. 443X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure secondary to Hypertensive Heart Disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 13, 1953, to July 17, 1953 that I last saw the deceased alive on 7-17-1953, and that death occurred at 10:30 a.m. from the causes and on the date stated above.

23A. SIGNATURE

SND

23b. ADDRESS

M. D. South Baltimore Gen. Hosp. 7/17/53

23c. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

July 20/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25. RECEIVED BY

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

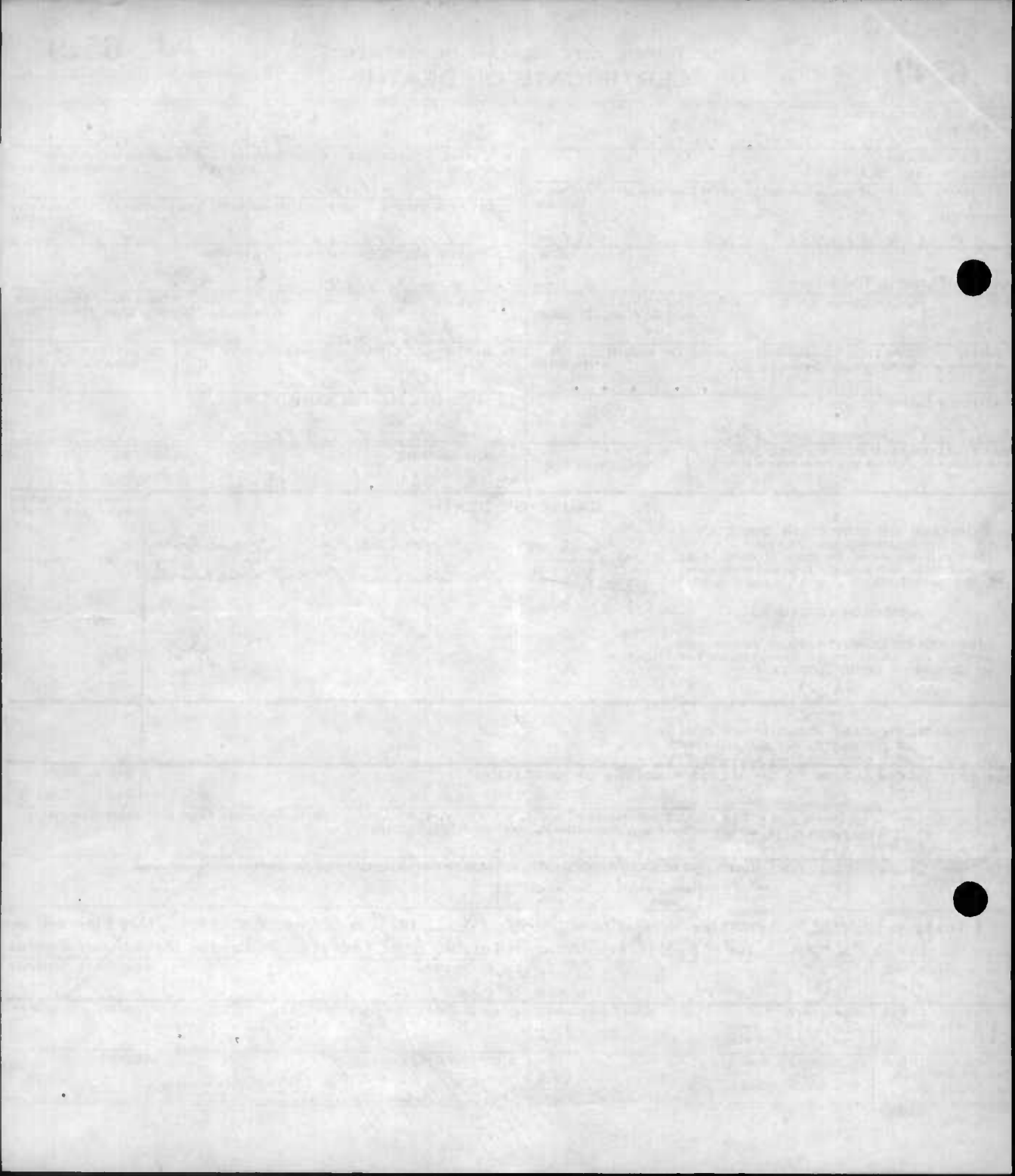
ADDRESS

101 Edmondson Ave.

JL 20 1953

VS 150

390 050





-352

3 6550

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6550  
Registered No.

TH NO.

NAME OF DECEASED  
(Type or Print)

Walter Carl Katenkamp

2. DATE  
OF  
DEATH

July 17/53.

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF

(If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

2 N. Broadway

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2 N. Broadway

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

May 1, 1890

9. AGE (In years

last birthday)

63

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR

Warrington Inds.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Walter William T. Katenkamp

14. MOTHER'S MAIDEN NAME

Pauline Scharrer

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No or unknown)

16. SOCIAL

SECURITY NO.

218 18 2057

17. INFORMANT (Brother)

ADDRESS

Wm. E. Katenkamp, 4006 Edmondson Ave

8. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Haemorrhage

DUE TO

## ANTECEDENT CAUSES

(B)

Myocarditis chronic

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Cirrhosis of the Liver

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1953 to 7-16, 1953, that I last saw the  
deceased alive on 7-16, 1953, and that death occurred at 11:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Social Snyder

23B. ADDRESS

1635 E. Baltimore

23C. DATE SIGNED

7-17-53

24A. BURIAL, CREMA-  
TION (Specify)

24B. DATE

July 20/53

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Pk.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

25A. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Harry T. Witzke

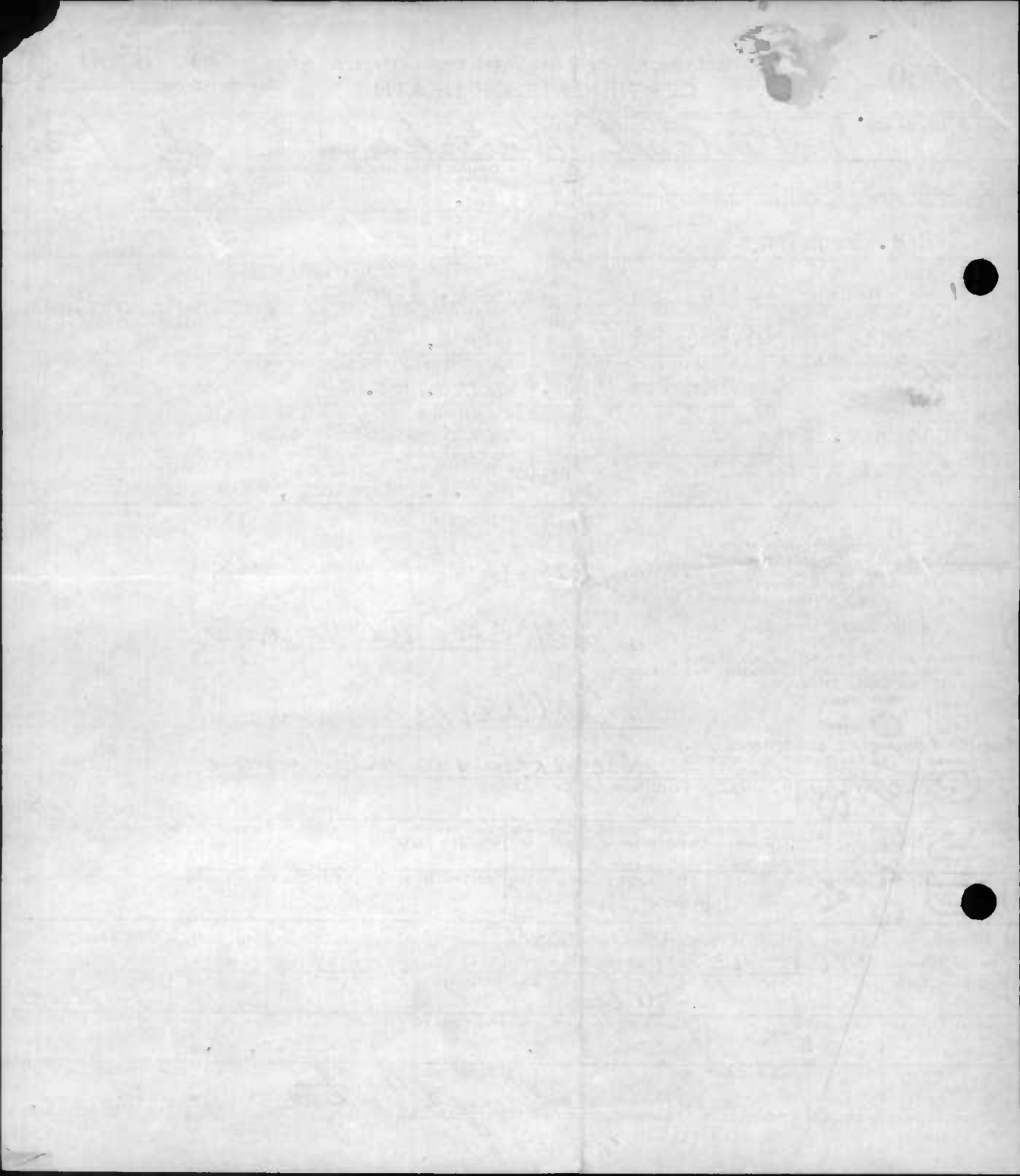
25B. FUNERAL DIRECTOR

ADDRESS

01 Edmondson Ave.

VS 150

39078



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered 53 6551

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NORMAN

BROWN

2. DATE  
OF  
DEATH

July 16, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

22-01

D. STREET ADDRESS (If rural, give location)

109 W. Hill Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

7/4/1898

9. AGE (In years  
last birthday)

55

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Barber Shop

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Mose Brown

14. MOTHER'S MAIDEN NAME

Tillie Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23b. CHIEF MEDICAL EXAMINER..... ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER..... ☒

July 16, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/20/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Ct.

24D. LOCATION (City, town, or county)

Baltimore, City.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1020

50

1020

1020

50

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OSCAR CLAVON

2. DATE  
OF  
DEATH

7/18/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

South Baltimore General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 23-01

D. STREET ADDRESS (If rural, give location)

201 W Cross St

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

7/14/52

9. AGE (in years  
last birthday)

1

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wallace Clavon

14. MOTHER'S MAIDEN NAME

Essie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Essie Jackson 201 W Cross St

ADDRESS

18. 492X

## CAUSE OF DEATH.

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Interstitial pneumonitis

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk M.D.

23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

7-18-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 20 1953

Thurston Hall

Isaac H. Brown &amp; Son

Completed - 7/16/53



L-620  
53 6553

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6553  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Loretta Lurz

2. DATE  
OF  
DEATH

July 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Mary's Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

Lifetime

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-14

D. STREET ADDRESS (If rural, give location)

6 Highland Rd.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Timothy Keating

14. MOTHER'S MAIDEN NAME

Mary Driscoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT ADDRESS

Mr. Lurz 2407 Roslyn Ave.

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cd of ascending colon  
DUE TO

1 YR (?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pneumonia

2 days

19A. DATE OF OPERATION

Nov. 1952

19B. MAJOR FINDINGS OF OPERATION

Cd ascending colon

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1953, to July 18, 1953, that I last saw the deceased alive on July 18, 1953, and that death occurred at 6:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert A. Moore Jr. M.D.

23B. ADDRESS

May Hosp.

23C. DATE SIGNED

July 18, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

July 21, 1953 Holy Redeemer

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Chas F. Evans & Son

118 W. Mt. Royal Ave.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of medical examiner: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Date of filing: \_\_\_\_\_

14. File number: \_\_\_\_\_

15. Remarks: \_\_\_\_\_

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| X-453<br>53 6554  |                                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | 53 6554<br>Registered No.   |  |
|---|----------------------------------|---|---|---|--|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>EVA E. Xylander</i>   |   | 2. DATE OF DEATH<br><i>JUL 18 1953</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Med. Cpl 3</i>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-05</i>  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>33</i> <i>JOHNS HOPKINS HOSPITAL</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>327 E. North Ave.</i>   |   | E. NORTH AVE.   |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | 8. DATE OF BIRTH<br><i>4-18-1898</i>  |   | 9. AGE (In years last birthday) <i>55</i><br>If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |  |
| 5. SEX<br><i>female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i> |
| 13. FATHER'S NAME<br><i>John Earles</i>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i>  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><i>214-18-7466</i>   |   | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |  |
| 18. <i>443X</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Sub arachnoid hemorrhage</i><br>DUE TO<br>ANTECEDENT CAUSES<br><i>Hypertensive cardio-vascular dis.</i><br>DUE TO<br>(C) _____ |                                  | CAUSE OF DEATH  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |   |  |
| 19A. DATE OF OPERATION <i>7</i>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                 |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                    |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>7-17-1953</i> to <i>7-18-1953</i> , that I last saw the deceased alive on <i>7-18-1953</i> , and that death occurred at <i>3:10 A. M.</i> , from the causes and on the date stated above.   |                                  |   |   |   |  |
| 23A. SIGNATURE<br><i>Henry H. Wagner Jr.</i>  |                                  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |   | 23C. DATE SIGNED<br><i>7/18/53</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 24B. DATE<br><i>7/21/53</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Parkville Md.</i>   |                                  | 24E. FUNERAL DIRECTOR<br><i>Wm. Cook Inc.</i>   |   | 24F. ADDRESS<br><i>1217 St. Paul St.</i>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>Jul 20 1953</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington</i>  |   | VS 150  |  |

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

|   |  |                                  |  |  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|--|--|
| <p>1. Name of Deceased</p>              |  | <p>2. Sex</p>                    |  | <p>3. Race</p>                           |  | <p>4. Date of Birth</p>                |  | <p>5. Date of Death</p>                  |  |
| <p>6. Place of Birth</p>                |  | <p>7. Usual Residence</p>        |  | <p>8. Cause of Death</p>                 |  | <p>9. Manner of Death</p>              |  | <p>10. Signature of Registrar</p>        |  |
| <p>11. Signature of Physician</p>       |  | <p>12. Signature of Coroner</p>  |  | <p>13. Signature of Medical Examiner</p> |  | <p>14. Signature of Health Officer</p> |  | <p>15. Signature of Funeral Director</p> |  |
| <p>16. Signature of Burial Director</p> |  | <p>17. Signature of Cemetery</p> |  | <p>18. Signature of Burial</p>           |  | <p>19. Signature of Burial</p>         |  | <p>20. Signature of Burial</p>           |  |

5-300

53 6555

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6555

Registered No. \_\_\_\_\_

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

SAMUEL BATTEE

2. DATE  
OF  
DEATH

JULY 18, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

SAINT JOSEPH'S HOSPITAL

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

East Electric Co.

FATHER'S NAME

Louis Battee

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

8/3/1898

9. AGE (in years last birthday)

54

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Marian Travenner

17. INFORMANT

ADDRESS

Chas. Strohl 611 S. Tolson St

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY T.B., MILLIARY

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

22. I hereby certify that I attended the deceased from JULY 18, 1953, to JULY 18, 1953 that I last saw the deceased alive on JULY 18, 1953, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Hubert J. Sebastian

M. D.

23B. ADDRESS

St. Joseph's Hospital

23C. DATE SIGNED

July 18/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/22/53

24C. NAME OF CEMETERY OR CREMATORY

Balto

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul St

VS 150

5645E

1022

RECEIVED IN THE DEPARTMENT  
CENTRAL EXCHANGE

1





-325

53 6556

53 6556

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

NAME OF DECEASED  
(Last name or Print)

Mortimer C. Cutcher

2. DATE  
OF  
DEATH

July 18, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore General Hospital

Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10. USUAL OCCUPATION (Give kind of work)

Housewife

10B. KIND OF BUSINESS OR

Own House

FATHER'S NAME

Wm. P. Horstman

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

July 2, 1895

9. AGE (In years  
last birthday)

58

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Lena Wittman

17. INFORMANT

ADDRESS

Eleanor Serani 3900 Rokeby Rd

18. 175X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinoma of  
abdominal organs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

12/20/52

19B. MAJOR FINDINGS OF OPERATION

Ca of ovaries &amp; metastasis to omentum &amp; peritoneum

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1953, to July 18, 1953, that I last saw the deceased alive on July 18, 1953, and that death occurred at 4:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Romulo V. Bero

M. D.

23B. ADDRESS

23C. DATE SIGNED

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

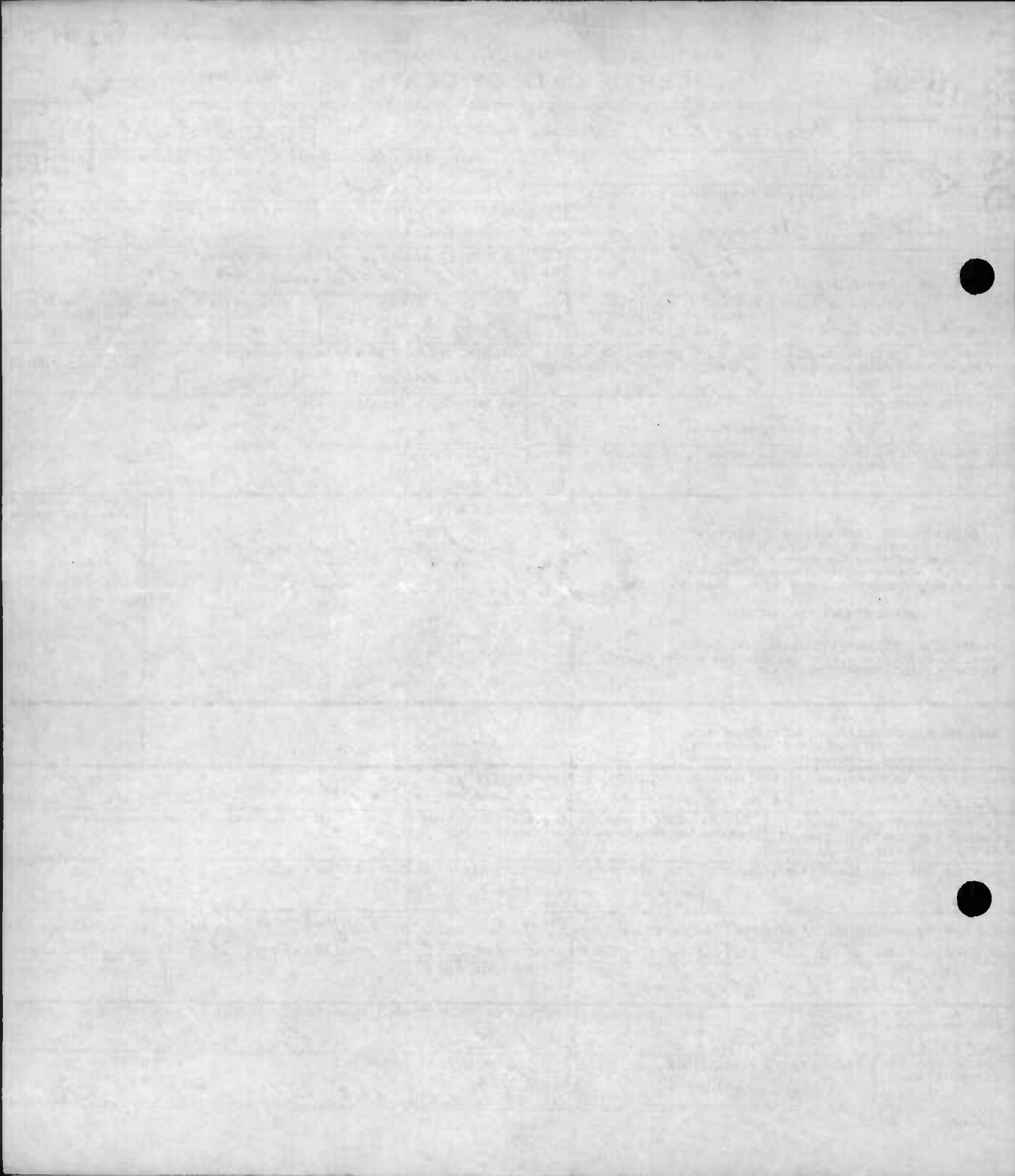
ADDRESS

Wm Cook Inc. 1217 St. Paul St.

JUL 20 1953

VS 150

690 YG



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6557  
Registered No. 53 6557

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LYDIA RITCH

2. DATE  
OF  
DEATH

July 17, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

The Marylander Apts.

St. Paul & University Pkwy.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

The Marylander Apts.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar. 29, 1909

9. AGE (In years  
last birthday)

44

If Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Washington State

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Rosenow

14. MOTHER'S MAIDEN NAME

Mary -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

Mrs. J. Rogasner-1646 Hillcrest Rd. / Pa.

ADDRESS

18. 162X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Carcinomatosis  
DUE TO (Liver, omentum, kidneys, etc., biopsy obtained from Liver)

3 months.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Probable primary Pulmonary Carcinoma  
DUE TO pathological report Dr. Merkel, Union Memorial Hospital, also X-Ray findings

6 months

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
June 20th 1953

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED Carcinoma (abdomen)

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19th, 1953, to July 17th, 1953, that I last saw the deceased alive on July 16, 1953, and that death occurred at 3.30 Am., from the causes and on the date stated above.

23A. SIGNATURE

Erwin E. Mayer, M.D.

23B. ADDRESS

The Esplanade (17)

23C. DATE SIGNED

July 18 '53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/20/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

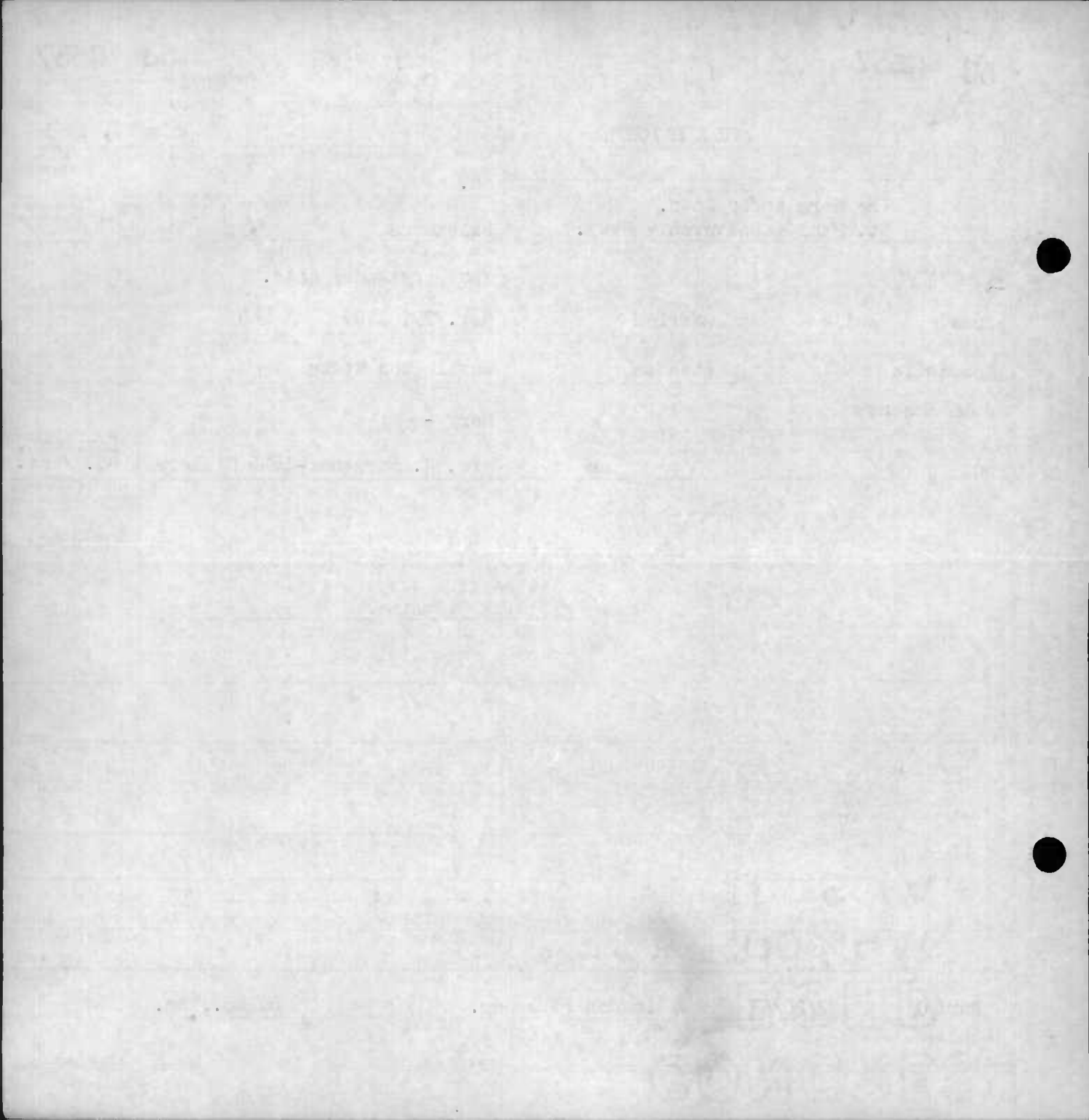
Huntington Halligan, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tischer & Sons

ADDRESS

Balto. 17, Md.



FJ 171703

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6558

53 6558  
BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Louis Dieterich</b>   |                                  | 2. DATE OF DEATH <b>7-19-1953</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>28-31</b>                  |  |
| c. Length of stay in Baltimore <b>life</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5252 Reisterstown Rd.</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>Jan. 6, 1906</b>                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bricklayer</b>                                      |                                  | 9. AGE (in years last birthday)<br><b>47</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Frederick A. Dietrich</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lula A. --</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>217-07-2270</b>  |  |
| 17. INFORMANT<br><b>B.C.H. 4940 Eastern Ave. (record)</b>   |                                  | ADDRESS <input checked="" type="checkbox"/>  |  |

|   |                |                                  |
|---|----------------|----------------------------------|
| 18. <b>002X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>Tuberculosis</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>-</b><br>DUE TO<br>(C) | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|----------------|----------------------------------|

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><b>7-3-1953</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Tracheotomy</b>                                    | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from **6 - 30 - 1953**, to **7 - 19 - 1953**, that I last saw the deceased alive on **7 - 19 - 1953**, and that death occurred at **7:20A.m.**, from the causes and on the date stated above.

|   |  |                                      |
|---|--|--------------------------------------|
| 23A. SIGNATURE<br><b>H. J. Williams</b> | 23B. ADDRESS<br><b>4940 Eastern Avenue</b> | 23C. DATE SIGNED<br><b>7-19-1953</b> |
|---|--|--------------------------------------|

|  |                             |   |   |
|--|-----------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7.22.53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |
|--|-----------------------------|---|---|

|  |   |   |                                  |
|--|---|---|----------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 20 1953</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>J. S. Pickens &amp; Sons</b> | ADDRESS<br><b>Balto. 17, Md.</b> |
|--|---|---|----------------------------------|

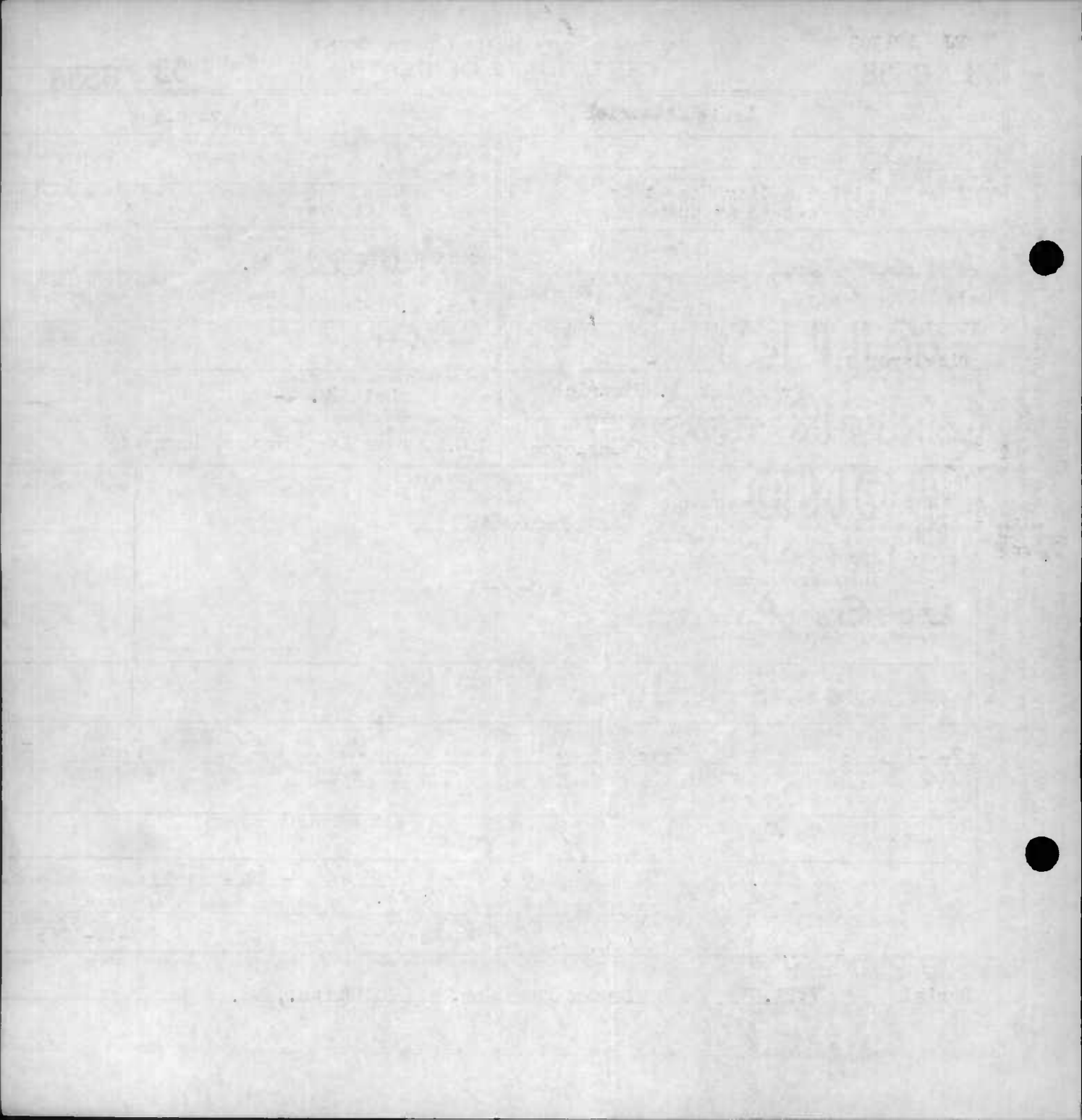
VS 150

50424

Balto. 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





3-640  
53 6559BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6559  
Registered No.

|  |                                   |   |                                      |   |   |
|--|-----------------------------------|---|--------------------------------------|---|---|
| BIRTH NO.  |                                   | 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. Martin Edward Bayrle</b>  |                                      | 2. DATE OF DEATH<br><b>July 18, 1953</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>YES</b>   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |                                      |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bon Secours Hospital</b>   |                                   | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                            |                                      |   |   |
| 7. Length of stay in Baltimore <b>Life-time</b>  |                                   | 8. STREET ADDRESS (If rural, give location)<br><b>1528 Windenere Ave., Balt.-14-Md.</b>                                     |                                      |   |   |
| 9. SEX<br><b>Male</b>  | 10. COLOR OR RACE<br><b>White</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 12. DATE OF BIRTH<br><b>3/6/1896</b> | 13. AGE (In years last birthday)<br><b>57</b>                                       | 14. If Under 1 Year: Months: Days; If Under 24 Hours: Hours: Min. |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerical</b>  |                                   | 16. KIND OF BUSINESS OR INDUSTRY<br><b>Glenn L. Martin Co.</b>  |                                      | 17. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>             |   |
| 18. FATHER'S NAME<br><b>E. Martin Bayrle</b>   |                                   | 19. MOTHER'S MAIDEN NAME<br><b>Catherine Leasch</b>   |                                      | 20. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (es, no or unknown)<br><b>yes</b>  |                                   | 22. SOCIAL SECURITY NO.<br><b>217-05-5597</b>   |                                      | 23. INFORMANT ADDRESS<br><b>Mrs. Anne E. Bayrle-2804 Beechland Ave.</b>             |   |
| 24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Infarction</b>                   |                                   | 25. INTERVAL BETWEEN ONSET AND DEATH  |                                      |   |   |
| 26. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Heart Block</b>   |                                   | 27. DUE TO<br><b>Coronary Infarction</b>  |                                      |   |   |
| 28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                   | 29. DUE TO  |                                      |   |   |
| 30. DATE OF OPERATION<br><b>0</b>  |                                   | 31. MAJOR FINDINGS OF OPERATION   |                                      | 32. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                                   | 34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                     |                                      | 35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |   |
| 36. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                   | 37. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |                                      | 38. HOW DID INJURY OCCUR?   |   |
| 39. I hereby certify that I attended the deceased from <b>7/13</b> 1953, to <b>7/18</b> 1953, that I last saw the deceased alive on <b>7/17</b> 1953, and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above. |                                   |   |                                      |   |   |
| 40. SIGNATURE<br><b>A.C. Knight</b>  |                                   | 41. ADDRESS<br><b>Bon Secours Hospital</b>  |                                      | 42. DATE SIGNED<br><b>7/18/53</b>   |   |
| 43. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                   | 44. DATE<br><b>7/22/53</b>  |                                      | 45. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem.</b>                 |   |
| 46. LOCATION (City, town, or county)<br><b>Arlington, Va.</b>  |                                   | 47. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem.</b>   |                                      | 48. LOCATION (City, town, or county)<br><b>Arlington, Va.</b>                       |   |
| 49. DATE RECEIVED BY LOCAL REGISTRAR<br><b>7/20/53</b>   |                                   | 50. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |                                      | 51. FUNERAL DIRECTOR<br><b>21 Wm. J. Tichner &amp; Sons</b>                         |   |
| 52. ADDRESS<br><b>Balto 17. Md.</b>  |                                   | 53. ADDRESS<br><b>Balto 17. Md.</b>   |                                      | 54. ADDRESS<br><b>Balto 17. Md.</b>   |   |

100-100000

THE UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000

INVESTIGATION OF THE  
ACTS OF VIOLENCE

IN THE CITY OF NEW YORK

ON THE PART OF THE  
BLACK PANTHER PARTY

AND THE ASSOCIATED  
BLACK PANTHER PARTY

IN THE CITY OF NEW YORK

ON THE PART OF THE  
BLACK PANTHER PARTY

AND THE ASSOCIATED  
BLACK PANTHER PARTY

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BLACK PANTHER PARTY

IN THE CITY OF NEW YORK

ON THE PART OF THE  
BLACK PANTHER PARTY

AND THE ASSOCIATED  
BLACK PANTHER PARTY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|   |                                 |  |   |  |                               |
|---|---------------------------------|--|---|--|-------------------------------|
| 53 6560   |                                 | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 53 6560   |                               |
| BIRTH NO.   |                                 | CERTIFICATE OF DEATH   |   |  |                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Jay Lee Mitchell</u>  |                                 | 2. DATE OF DEATH <u>July 17, 1953</u>  |   |  |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Acc. Room</u>  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md.</u><br>B. COUNTY <u>Baltimore</u> |   |  |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>   |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>  |   |  |                               |
| c. Length of stay in Baltimore  |                                 | D. STREET ADDRESS (If rural, give location) <u>2451 Woodward Ave</u>   |   |  |                               |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   | 8. DATE OF BIRTH <u>March 28, 1901</u>                    | 9. AGE (In years last birthday) <u>52</u>  | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>   |                                 |  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |  |                               |
| 13. FATHER'S NAME <u>Willam Mitchell</u>  |                                 |  | 14. MOTHER'S MAIDEN NAME <u>Sallie Brown</u>              |  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                 |  | 16. SOCIAL SECURITY NO.                                   |  |                               |
| 17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>   |                                 |  | ADDRESS   |  |                               |
| 18. <u>570.5</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) <u>Intestinal Obstruction</u><br>DUE TO<br>(B) <u>abdominal adhesions</u><br>DUE TO<br>(C) <u></u><br>INTERVAL BETWEEN ONSET AND DEATH |                                 | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.             |   |  |                               |
| II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.  |                                 |  |   |  |                               |
| 19A. DATE OF OPERATION <u>7-17-53</u>   |                                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>   |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II <u></u>   |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |                                 | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u></u>  |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u></u> |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>   |                                 | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                     |   | 21F. HOW DID INJURY OCCUR? <u></u>   |                               |
| 22. I hereby certify that I attended the deceased from <u>7-17, 1953</u> , to <u>7-17, 1953</u> , that I last saw the deceased alive on <u>7-17, 1953</u> , and that death occurred at <u>7:40 p.m.</u> , from the causes and on the date stated above.   |                                 |  |   |  |                               |
| 23A. SIGNATURE <u>James V. Maloney Jr.</u>  |                                 | 23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>   |   | 23C. DATE SIGNED <u>7/18/53</u>  |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                                 | 24B. DATE <u>7-21-53</u>   |   | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>                         |                               |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>   |                                 | 24E. DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 20 1953</u>   |   | 24F. REGISTRAR'S SIGNATURE <u>Huntington Williams</u>                            |                               |
| 24G. FUNERAL DIRECTOR <u>W. H. Starnes &amp; Co.</u>  |                                 | 24H. ADDRESS <u>578 W</u>  |   | 24I. VS 150  |                               |
| 780-99  |                                 |  |   |  |                               |

1912

STATE OF TEXAS

1912

County of \_\_\_\_\_ State of Texas

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of Texas

do hereby certify that \_\_\_\_\_

is the true and correct copy of \_\_\_\_\_

as the same appears from the \_\_\_\_\_

records of the \_\_\_\_\_

County of \_\_\_\_\_ State of Texas

in and to which \_\_\_\_\_

has been duly recorded \_\_\_\_\_

and the same is hereby \_\_\_\_\_

certified to be the true and correct \_\_\_\_\_

copy of the \_\_\_\_\_

as the same appears from the \_\_\_\_\_

records of the \_\_\_\_\_

County of \_\_\_\_\_ State of Texas

in and to which \_\_\_\_\_

has been duly recorded \_\_\_\_\_

S-536

61

Registered No. 53-6561

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Last, first, middle initial, or Print)<br><b>Snyder, William James</b>  |                                  | 2. DATE OF DEATH<br><b>July 17, 1953</b>  |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Joseph's Hospital</b>   |                                  | C. CITY OR TOWN<br><b>Fullerton</b>   |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>41</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>Snyder Lane</b>   |   |
| 7. SEX<br><b>Male</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 10. DATE OF BIRTH<br><b>July 28, 1886</b>                           |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>Farmer</b>  |                                  | 12. AGE (In years last birthday)<br><b>66</b>   | 13. If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 14. FATHER'S NAME<br><b>John Snyder</b>   |                                  | 15. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>W.W. I</b>   |                                  | 17. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 18. SOCIAL SECURITY NO.<br><b>none</b>  |                                  | 19. MOTHER'S MAIDEN NAME<br><b>Mary Tremper</b>   |   |
| 20. INFORMANT<br><b>Miss Cecelia Snyder, Fullerton, Md.</b>   |                                  | 21. ADDRESS   |   |
| 22. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Subhepatic abscess</b><br><del>PULMONARY</del><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) Adenocarcinoma of the bile duct disseminated throughout the liver</b><br><b>(C) with cardiac failure, mild Anteriosclerotic cardiovascular disease</b> |                                  |   |   |
| 23. DATE OF OPERATION<br><b>0</b>   |                                  | 24. MAJOR FINDINGS OF OPERATION   |   |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  | 26. INTERVAL BETWEEN ONSET AND DEATH  |   |
| 27. DATE OF OPERATION<br><b>0</b>   |                                  | 28. MAJOR FINDINGS OF OPERATION   |   |
| 29. DATE OF OPERATION<br><b>0</b>   |                                  | 30. MAJOR FINDINGS OF OPERATION   |   |
| 31. DATE OF OPERATION<br><b>0</b>   |                                  | 32. MAJOR FINDINGS OF OPERATION   |   |
| 33. DATE OF OPERATION<br><b>0</b>   |                                  | 34. MAJOR FINDINGS OF OPERATION   |   |
| 35. DATE OF OPERATION<br><b>0</b>   |                                  | 36. MAJOR FINDINGS OF OPERATION   |   |
| 37. DATE OF OPERATION<br><b>0</b>   |                                  | 38. MAJOR FINDINGS OF OPERATION   |   |
| 39. DATE OF OPERATION<br><b>0</b>   |                                  | 40. MAJOR FINDINGS OF OPERATION   |   |
| 41. DATE OF OPERATION<br><b>0</b>   |                                  | 42. MAJOR FINDINGS OF OPERATION   |   |
| 43. DATE OF OPERATION<br><b>0</b>   |                                  | 44. MAJOR FINDINGS OF OPERATION   |   |
| 45. DATE OF OPERATION<br><b>0</b>   |                                  | 46. MAJOR FINDINGS OF OPERATION   |   |
| 47. DATE OF OPERATION<br><b>0</b>   |                                  | 48. MAJOR FINDINGS OF OPERATION   |   |
| 49. DATE OF OPERATION<br><b>0</b>   |                                  | 50. MAJOR FINDINGS OF OPERATION   |   |
| 51. DATE OF OPERATION<br><b>0</b>   |                                  | 52. MAJOR FINDINGS OF OPERATION   |   |
| 53. DATE OF OPERATION<br><b>0</b>   |                                  | 54. MAJOR FINDINGS OF OPERATION   |   |
| 55. DATE OF OPERATION<br><b>0</b>   |                                  | 56. MAJOR FINDINGS OF OPERATION   |   |
| 57. DATE OF OPERATION<br><b>0</b>   |                                  | 58. MAJOR FINDINGS OF OPERATION   |   |
| 59. DATE OF OPERATION<br><b>0</b>   |                                  | 60. MAJOR FINDINGS OF OPERATION   |   |
| 61. DATE OF OPERATION<br><b>0</b>   |                                  | 62. MAJOR FINDINGS OF OPERATION   |   |
| 63. DATE OF OPERATION<br><b>0</b>   |                                  | 64. MAJOR FINDINGS OF OPERATION   |   |
| 65. DATE OF OPERATION<br><b>0</b>   |                                  | 66. MAJOR FINDINGS OF OPERATION   |   |
| 67. DATE OF OPERATION<br><b>0</b>   |                                  | 68. MAJOR FINDINGS OF OPERATION   |   |
| 69. DATE OF OPERATION<br><b>0</b>   |                                  | 70. MAJOR FINDINGS OF OPERATION   |   |
| 71. DATE OF OPERATION<br><b>0</b>   |                                  | 72. MAJOR FINDINGS OF OPERATION   |   |
| 73. DATE OF OPERATION<br><b>0</b>   |                                  | 74. MAJOR FINDINGS OF OPERATION   |   |
| 75. DATE OF OPERATION<br><b>0</b>   |                                  | 76. MAJOR FINDINGS OF OPERATION   |   |
| 77. DATE OF OPERATION<br><b>0</b>   |                                  | 78. MAJOR FINDINGS OF OPERATION   |   |
| 79. DATE OF OPERATION<br><b>0</b>   |                                  | 80. MAJOR FINDINGS OF OPERATION   |   |
| 81. DATE OF OPERATION<br><b>0</b>   |                                  | 82. MAJOR FINDINGS OF OPERATION   |   |
| 83. DATE OF OPERATION<br><b>0</b>   |                                  | 84. MAJOR FINDINGS OF OPERATION   |   |
| 85. DATE OF OPERATION<br><b>0</b>   |                                  | 86. MAJOR FINDINGS OF OPERATION   |   |
| 87. DATE OF OPERATION<br><b>0</b>   |                                  | 88. MAJOR FINDINGS OF OPERATION   |   |
| 89. DATE OF OPERATION<br><b>0</b>   |                                  | 90. MAJOR FINDINGS OF OPERATION   |   |
| 91. DATE OF OPERATION<br><b>0</b>   |                                  | 92. MAJOR FINDINGS OF OPERATION   |   |
| 93. DATE OF OPERATION<br><b>0</b>   |                                  | 94. MAJOR FINDINGS OF OPERATION   |   |
| 95. DATE OF OPERATION<br><b>0</b>   |                                  | 96. MAJOR FINDINGS OF OPERATION   |   |
| 97. DATE OF OPERATION<br><b>0</b>   |                                  | 98. MAJOR FINDINGS OF OPERATION   |   |
| 99. DATE OF OPERATION<br><b>0</b>   |                                  | 100. MAJOR FINDINGS OF OPERATION  |   |

Vs 150 1553

10010





G-600

6562

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6562

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

Florence Gray

2. DATE  
OF  
DEATH

July 19-1953

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF  
HOSPITAL OR  
NURSING HOME  
(If not in hospital or institution, give street address or location)

4215 Springwood Ave

Length of stay in Baltimore

EX 6. COLOR OR RACE

F W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

FATHER'S NAME

Kenneth Bayne

9. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

8. DATE OF BIRTH

May 22-1879

9. AGE (In years  
last birthday)

74

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Caroline Curtis

17. INFORMANT

Mrs Edna Putter

ADDRESS

4215 Springwood Ave

18. 191X

CAUSE OF DEATH

Pulmonary Embolism

Cancer of face 1950

(A) DUE TO

(B) DUE TO

(C) DUE TO

(A) DUE TO

(B) DUE TO

(C) DUE TO

(A) DUE TO

(B) DUE TO

(C) DUE TO

(A) DUE TO

(B) DUE TO

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(A) DUE TO

(B) DUE TO

(C) DUE TO

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arterio Sclerosis Aneurysm

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK ☐ NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1953, to July 19, 1953, that I last saw the  
deceased alive on July 19, 1953, and that death occurred at 3001 Shannon Drive from the causes and on the date stated above.

23A. SIGNATURE

H. H. Keederson

23B. ADDRESS

3001 Shannon Drive

23C. DATE SIGNED

7-20-53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/53

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

25. RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

H. H. Keederson

25. FUNERAL DIRECTOR

Kasselin Funeral Home

ADDRESS

2401 Belair Rd

Dr. Anderson

72-460

53 6563

53-15604

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6563

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 1. NAME OF DECEASED<br>or Print <i>Maryanna Miller</i>  |                                   | 2. DATE OF DEATH<br><i>July 18/53</i>  |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland <i>1807 E. Pratt St</i>  |                                   | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <i>Ind.</i><br>B. COUNTY <i>Baltimore</i> |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>1807 E. Pratt St</i>  |                                   | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>   |  |
| 7. LENGTH OF STAY IN BALTIMORE<br><i>2-0-2</i>  |                                   | 8. STREET ADDRESS (If rural, give location)<br><i>1807 E. Pratt St</i>   |  |
| 9. SEX<br><i>Female</i>   | 10. COLOR OR RACE<br><i>White</i> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Child</i>   | 12. DATE OF BIRTH<br><i>July 11/53</i> |
| 13. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)   |                                   | 14. CITIZEN OF WHAT COUNTRY?<br><i>7</i>   |  |
| 15. FATHER'S NAME<br><i>Joseph Miller</i>   |                                   | 16. MOTHER'S MAIDEN NAME<br><i>Elizabeth Sherba</i>  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  |                                   | 18. SOCIAL SECURITY NO.<br><i>Joseph Miller</i>  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Acute respiratory infection (Pneumonia)</i>              |                                   | 20. INTERVAL BETWEEN ONSET AND DEATH<br><i>18 hrs.</i>   |  |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Conquitted infarctate anus - c.<br/>recto vaginal fistula.</i>   |                                   | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>6-6-</i>         |  |
| 23. DATE OF OPERATION<br><i>0</i>   |                                   | 24. MAJOR FINDINGS OF OPERATION  |  |
| 25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  |                                   | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                   | 28. HOW DID INJURY OCCUR?  |  |
| 29. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                   | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                      |  |
| 31. I hereby certify that I attended the deceased from <i>July 17, 1952</i> , to <i>July 18, 1952</i> , that I last saw the deceased alive on <i>July 17, 1952</i> , and that death occurred at <i>12:30 p.m.</i> , from the causes and on the date stated above. |                                   |  |  |
| 32. SIGNATURE<br><i>Dr. D. L. L...</i>  |                                   | 33. ADDRESS<br><i>1765 Patterson Park Ave</i>  |  |
| 34. DATE<br><i>July 20/53</i>   |                                   | 35. NAME OF CEMETERY OR CREMATORY<br><i>Holy Rosary</i>  |  |
| 36. LOCATION (City, town, or county) (State)<br><i>Baltimore</i>  |                                   | 37. FUNERAL DIRECTOR<br><i>Fred W. Ozagowski</i>   |  |
| 38. ADDRESS<br><i>1930 Eastern Ave.</i>   |                                   | 39. RECEIVED BY<br><i>Huntington Williams</i>  |  |
| 40. CAL REGISTRAR   |                                   | 41. VS 150   |  |

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

J-525  
53 6564BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6564  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

JENS P. JOHANSEN

2. DATE  
OF  
DEATH

7/17/53

PLACE OF DEATH:

Baltimore City, Maryland

South Balto. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

MD.

B. COUNTY

before admission)

FULL NAME OF

HOSPITAL OR  
INSTITUTION

South Balto. Gen. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-05

D. STREET ADDRESS (If rural, give location)

3706 WEST Bay Ave.

Length of stay in Baltimore

EX

6. COLOR OR RACE

7. SINGLE (MARRIED)

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5-14-90

9. AGE (in years

last birthday)

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

USUAL OCCUPATION (Give kind of  
work during part of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Norway

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Fritjof

14. MOTHER'S MAIDEN NAME

Hanna Jackson

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No.

16. SOCIAL

SECURITY NO.

21305-5056

17. INFORMANT

ADDRESS

Family - SAME

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 17, 1953, to July 17, 1953, that I last saw the  
deceased alive on July 17, 1953, and that death occurred at 6:00 PM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

TE RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

54430 130 E. Fort Ave.





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6565W-630  
53 6565  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

JOHN H. WIRTH

2. DATE  
OF  
DEATH

7-18-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

S.B.G.H.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 25-04

D. STREET ADDRESS (If rural, give location)

4026 63 St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

5-8-05

9. AGE (In years  
last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mach.

10B. KIND OF BUSINESS OR  
INDUSTRY

Kelly Truck

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William M.

14. MOTHER'S MAIDEN NAME

Martha G. Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18. 322.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

ACUTE ALCOHOLISM

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

PULMONARY EDEMA

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ WORK NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☒

23C. DATE SIGNED

7-18-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B.

24B. DATE

7-22-53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



M-620  
53 6566BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6566  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                              |  |  |   |   |
|---|------------------------------|--|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HILDA M. MYERS</b>   |                              |  | 2. DATE<br>OF<br>DEATH <b>7/18/53</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>8 East Barney Street</b>                                   |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Baltimore</b> |   |   |
| 5. FULL NAME OF<br>HOSPITAL OR<br>INSTITUTION<br><b>80</b>  |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 23-03</b>                                     |   |   |
| c. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                              |  | D. STREET ADDRESS (If rural, give location)<br><b>8 East Barney Street</b>   |   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify)<br><b>W</b> | 8. DATE OF BIRTH<br><b>1/17/02</b>   | 9. AGE (In years<br>last birthday)<br><b>51</b> | 10. Under 1 Year<br>Months: Days<br>11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of<br>work done during most of working life, even if retired)<br><b>Folder</b> |                              |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |   |   |
| 10B. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Gordon Packing Co.</b>   |                              |  | 12. CITIZEN OF<br>WHAT COUNTRY?  |   |   |
| 13. FATHER'S NAME<br><b>Jacob E. Helferstay</b>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie A. Smith</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>No</b>             |                              |  | 16. SOCIAL<br>SECURITY NO.   |   |   |
| 17. INFORMANT<br><b>Family - Same</b>   |                              |  | ADDRESS  |   |   |

|  |  |   |  |                                     |  |
|--|--|---|--|-------------------------------------|--|
| 18. <b>171X</b><br>I<br>DISEASE OR CONDITION DIRECTLY<br>LEADING TO DEATH<br>(This does not mean the mode of dying, e. g.,<br>heart failure, asthenia, etc. It means the disease,<br>injury or complication which caused death.) |  | CAUSE OF DEATH                            |  | INTERVAL BETWEEN<br>ONSET AND DEATH |  |
| ANTECEDENT CAUSES  |  | (A) <b>Acute Cardiac Failure</b>          |  | <b>1 da</b>                         |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING<br>RISE TO THE ABOVE CAUSE (A) STATING THE<br>UNDERLYING CONDITION LAST.  |  | DUE TO <b>Chronic Myocarditis</b>         |  | <b>6 mos</b>                        |  |
|  |  | (B) <b>Coronary artery<br/>metastases</b> |  | <b>1 yr</b>                         |  |
|  |  | (C) _____                                 |  |                                     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CON-<br>TRIBUTING TO THE DEATH, BUT NOT RELATED<br>TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |                                     |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or<br>shoot home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID<br>INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| TIME (Month) (Day) (Year) (Hour)<br>INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>WORK AT WORK |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6/10/53</b> , 19 <b>53</b> , to <b>7/18</b> , 19 <b>53</b> , that I last saw the<br>deceased alive on <b>7/18</b> , 19 <b>53</b> and that death occurred at <b>10:30 p.m.</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Joseph G. Laukaitis</b>  |  | 23B. ADDRESS<br><b>679 Washington Blvd</b>   |  | 23C. DATE SIGNED<br><b>7/20/53</b>  |  |
| 24A. BURIAL, CREMA-<br>TION, REMOVAL (Specify)<br><b>B</b>  |  | 24B. DATE<br><b>7/22/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                    |  |
| DATE RECEIVED BY<br>LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |  | 25. FUNERAL DIRECTOR<br><b>James L. McCully - 130 E. Fort Avenue</b>        |  |

CERTIFICATE OF DEATH

6/9 West Blvd.  
J. J. J. J. J.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6567**

TH NO.

NAME OF DECEASED  
(Last, first, middle, or initial)

**EDNA E. BOWMAN**

2. DATE  
OF  
DEATH

**7/18/53**

PLACE OF DEATH:

**Baltimore City, Maryland 1221 S. Charles St.**

3. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 23-02**

D. STREET ADDRESS (If rural, give location)  
**1221 S. Charles St.**

5. Length of stay in Baltimore

6. COLOR OR RACE  
**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**M**

8. DATE OF BIRTH  
**9/2/1891**

9. AGE (In years, last birthday)  
**61**

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)  
**Housework**

10b. KIND OF BUSINESS OR INDUSTRY  
**Home**

11. BIRTHPLACE (State or foreign country)  
**Baltimore**

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

**Robert P. Harrison**

14. MOTHER'S MAIDEN NAME

**Mary A. Sass**

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.  
**None**

17. INFORMANT ADDRESS  
**Family - Same**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO  
(B) DUE TO  
(C) DUE TO

**Coronary Heart disease  
Hypertension  
Arteriosclerosis**

**one day  
2 years**

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 0 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) (Minute)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1951**, 19**51**, to **July 18**, 19**53** that I last saw the deceased alive on **7/18/53**, and that death occurred at **5:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

BURIAL, CREMA-REMOVAL (Specify)  
**B**

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

25. RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**VS 150**

**Huntington 1921**

**James L. McCully - 130 E. Fort Avenue**

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

25/11/52 R



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6568**

**1. NAME OF DECEASED** (Type or Print) *Thomas Kevin Tunney*

**2. DATE OF DEATH** *7/20/53*

**3. PLACE OF DEATH:**  
Baltimore City, Maryland

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland* B. COUNTY *Baltimore*

**5. FULL NAME OF HOSPITAL OR INSTITUTION** (If not in hospital or institution, give street address or location)  
*Mercy Hospital, Inc.*

**6. CITY OR TOWN** (If outside corporate limits, write RURAL and give township)  
*Baltimore - 4*

**7. STREET ADDRESS** (If rural, give location)  
*630 Hastings Rd*

**8. LENGTH OF STAY IN BALTIMORE** *2 day*

**9. SEX** *Male*

**10. COLOR OR RACE** *White*

**11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)** *single*

**12. DATE OF BIRTH** *7/18/53*

**13. AGE (In years, last birthday)** *2*

**14. BIRTHPLACE (State or foreign country)** *Maryland*

**15. CITIZEN OF WHAT COUNTRY?**

**16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** *report*

**17. KIND OF BUSINESS OR INDUSTRY**

**18. FATHER'S NAME** *Robert Boone Tunney*

**19. MOTHER'S MAIDEN NAME** *Marjorie Kreuzer*

**20. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no or unknown) *no*

**21. SOCIAL SECURITY NO.**

**22. INFORMANT ADDRESS**

**18. 754.4**

**CAUSE OF DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

**19. DATE OF OPERATION** *7*

**20. MAJOR FINDINGS OF OPERATION**

**21. AUTOPSY?** YES ☒ NO ☐

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH**

**21B. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.)

**21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME (Month) (Day) (Year) (Hour)**

**21E. INJURY OCCURRED**

**21F. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from 7-18-53 to 7-20-53, that I last saw the deceased alive on 7-20-53, and that death occurred at 2:00 p. m., from the causes and on the date stated above.**

**23A. SIGNATURE** *Robert E. Ebers*

**23B. ADDRESS** *Mercy Hospital*

**23C. DATE SIGNED** *7/20/53*

**24A. BURIAL, CREMATION, REMOVAL (Specify)** *Burial*

**24B. DATE** *7/20/53*

**24C. NAME OF CEMETERY OR CREMATORY** *Cathedral*

**24D. LOCATION (City, town, or county)** *Old Frederick*

**25. DATE RECEIVED BY LOCAL REGISTRAR** *20/10/53*

**26. REGISTRAR'S SIGNATURE** *Huntington Williams*

**27. FUNERAL DIRECTOR ADDRESS** *J. J. Baker & Sons*

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

DATE OF REPORT: 10/10/68

REPORT OF:

BY:

7-200

3 6569

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6569

Registered No. \_\_\_\_\_

NAME OF DECEASED  
(Type or Print)

*Alma O Lewis*

2. DATE OF DEATH *7-17-53*

PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR INSTITUTION

*1647 71 Spring St  
404 yrs*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *md* B. COUNTY *9-09*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Balto*

D. STREET ADDRESS (If rural, give location)  
*1647 71 Spring St*

Length of stay in Baltimore

SEX *M* 6. COLOR OR RACE *C* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *W*

8. DATE OF BIRTH *3-6-1908* 9. AGE (In years last birthday) *45* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *Charleston N.C* 12. CITIZEN OF WHAT COUNTRY? *U.S*

FATHER'S NAME

14. MOTHER'S MAIDEN NAME

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *Mary Woodward  
Cecilia Mackett 1647 Spring*

18. *199.9* I *gum* DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) *Myo-Carditis* 4 mos  
DUE TO *Metastasis of*  
(B) *cancer and* 12 mos  
DUE TO *Hepatitis* 12 mos  
(C) *-*

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from *4-15-53* to *7/17-53*, that I last saw the deceased alive on *7-17-53*, and that death occurred at *5:05 a.m.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*7208A 1011 71 Calvary Tr. Dr*

2-15-23

Chas. O. Jones

1011 W. Grand St.  
Chicago, Ill.  
3-8-1908  
1011 W. Grand St.  
Chicago, Ill.  
2-15-23

1011 W. Grand St.  
Chicago, Ill.

1011 W. Grand St.  
Chicago, Ill.

1011 W. Grand St.  
Chicago, Ill.  
2-15-23

2-15-23

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6570  
Registered No.F. 520  
53 6570  
BIRTH NO.

|   |                                |   |   |  |  |
|---|--------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS SCHOFIELD FINCH</b>  |                                |   | 2. DATE OF DEATH<br><b>July 16, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>US Public Health Service Hospital</b><br><b>Wyman Pk. Drive &amp; 31st Street</b> |                                |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>16-05</b>               |  |  |
| c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days  |                                |   | D. STREET ADDRESS (If rural, give location)<br><b>2541 W. Lafayette Ave.</b>  |  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>Col</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>1/29/15</b>  |  | 9. AGE (In years last birthday)<br><b>38</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook &amp; Baker</b>          |                                | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>seafarer</b>              | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Schofield Finch</b>   |                                |   | 14. MOTHER'S MAIDEN NAME<br><b>Janet Taylor</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>           |                                | 16. SOCIAL SECURITY NO.<br><b>Yes- ?</b>                          | 17. INFORMANT ADDRESS<br><b>Records- US PHS Hospital, Balto, Md.</b>  |  |  |

|  |  |
|--|--|
| 18. <b>330X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Subarachnoid hemorrhage due to rupture of a cerebral vessel</b><br>DUE TO (A) <b>Spontaneous (recent)</b> |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (B)<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH  |  |

|  |   |
|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |
| 19A. DATE OF OPERATION<br><b>7</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II</b> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>               | 21F. HOW DID INJURY OCCUR?  |

|  |  |  |  |
|--|--|--|--|
| 22. I hereby certify that I attended the deceased from <b>July 16</b> , 19 <b>53</b> , to <b>July 16</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 16</b> , 19 <b>53</b> and that death occurred at <b>10:25 P.</b> m., from the causes and on the date stated above. |  |  |  |
| 23A. SIGNATURE<br><b>Nathan Schnaper, S.A. Surgeon (R)</b> M. D.   |  | 23B. ADDRESS<br><b>US PHS Hospital, Balto, Md.</b>   |  |
| 23C. DATE SIGNED<br><b>7/17/53</b>   |  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>13</b>   |  |
| 24B. DATE<br><b>7-21-53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Samuel W. Sullivan Jr</b><br><b>50055 1011 N. Arlington Ave</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 20 1953</b>   |  | REGISTRAR'S SIGNATURE<br><b>Samuel W. Sullivan Jr</b>  |  |

13

7-21-23

Arthur

George  
Lawrence H. Lawrence  
1011 W. Lawrence Ave



AB-172073

W-256

53 6571

53 6571

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Caroline Wachmer (CAROLINE WACHMER)

2. DATE  
OF  
DEATH

July 17-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

5523 O'Donnell St.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 3- 1877

9. AGE (In years  
last birthday)

75

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Owner

10B. KIND OF BUSINESS OR  
INDUSTRY

Monument Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

August Wachmer

14. MOTHER'S MAIDEN NAME

Minnie Hess

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMATION FROM  
Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. E903.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary Embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)CERTIFICATION APPROVED BY  
R. S. [Signature]  
CHIEF OR ASST. MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 12-1953

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Fracture right Hip

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

5523 O'Donnell St.

26/36

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

7- 8 1953

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell at home - Fell to floor

22. I hereby certify that I attended the deceased from 7-9-1953, to 7-17-1953, that I last saw the  
deceased alive on 7-17-1953, and that death occurred at 11:50 AM from the causes and on the date stated above.

23A. SIGNATURE

H. J. [Signature]

M. D.

23B. ADDRESS 4940 Eastern Ave.  
Baltimore City Hospitals23C. DATE SIGNED  
7-17-195324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/20/53

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
BALTO., 13, MD.

ADDRESS

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER

N 820.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

1971

1971

1971

[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

P-252.  
3 6572

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. <sup>53</sup>6572

TH NO.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Last name or Print) <i>Joseph Pajinas</i>  |                               | 2. DATE OF DEATH <i>July 17-53</i> <i>8:40 P.M.</i>   |   |
| 3. PLACE OF DEATH: <i>Baltimore City, Maryland</i>   |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>Little Sisters of the Poor</i> |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 21-02</i>                      |   |
| 6. LENGTH OF STAY IN BALTIMORE <i>7 years</i>  |                               | D. STREET ADDRESS (If rural, give location)<br><i>806 Washington Blvd Baltimore</i>   |   |
| 7. SEX <i>Male</i>   | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH <i>Oct 18 1884</i>   |
| 9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)   |                               | 10. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (in years last birthday) <i>68</i><br>If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |
| 11. FATHER'S NAME <i>Samuel Pajinas</i>  |                               | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                               | 14. MOTHER'S MAIDEN NAME <i>Anne Braliet</i>  |   |
| 15. SOCIAL SECURITY NO.  |                               | 17. INFORMANT <i>Little Sisters of the Poor</i> ADDRESS   |   |

|   |  |                             |                                  |
|---|--|-----------------------------|----------------------------------|
| 8. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH              | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO  |  | <i>Cerebral Hemorrhage-</i> | <i>1 week</i>                    |
| ANTECEDENT CAUSES   |  | (B) DUE TO                  | <i>Arterio Sclerosis</i>         |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (C) DUE TO                  | <i>5 yrs</i>                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                             |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 9A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from *July 1*, 19*53*, to *July 17*, 19*53* that I last saw the deceased alive on *July 17*, 19*53*, and that death occurred at *8:40 P.M.*, from the causes and on the date stated above.

|   |  |                                      |  |  |  |
|---|--|--------------------------------------|--|--|--|
| 23A. SIGNATURE <i>E. Gill Hall</i>                      |  | 23B. ADDRESS <i>1631 E North Ave</i> |  | 23C. DATE SIGNED <i>July 18-53</i>                     |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> |  | 24B. DATE <i>July 21, 1953</i>       |  | 24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>    |  |
| 24D. LOCATION (City, town, or county) <i>Baltimore</i>  |  | 24E. LOCATION (State) <i>Md.</i>     |  | 24F. LOCATION (City, town, or county) <i>Baltimore</i> |  |
| 24G. RECEIVED BY <i>Huntington Williams, M.D.</i>       |  | 24H. REGISTRAR'S SIGNATURE           |  | 24I. FUNERAL DIRECTOR <i>Reta Wiedefeld</i>            |  |
| 24J. ADDRESS <i>900 E. Biddle St</i>                    |  | 24K. ADDRESS                         |  | 24L. ADDRESS   |  |

VS 150



F-424  
53 6573BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6573  
Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle initial, or Print)

Fleagle, Mary M.

2. DATE  
OF  
DEATH July 17, 1953PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR

St. Joseph's Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

EX 6. COLOR OR RACE

F. W.  
USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)  
part-time domestic work7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married  
10b. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Michael Bufano

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-45-2597

8. DATE OF BIRTH

May 2-1897

9. AGE (In years  
last birthday)

56

If Under 1 Year  
Months Days Hours Min.

2 15

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Conchetta Petriaccone

17. INFORMANT

ADDRESS

Joseph F. J. 2900 Woodland Ave

8. 572.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Lower nephron nephrosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Intestinal obstruction due to adhesions

9a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

July 1st &amp; 13th, 1953 Diverticulum, 2d portion of duodenum; Postop. adhesions

20. AUTOPSY?

☐ NO ☒21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1953 to July 17, 1953 that I last saw the  
deceased alive on July 17, 1953, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial July 21-1953 Lorraine Park Cem.  
RECEIVED BY REGISTAR'S SIGNATURE  
AL REGISTRAR25. FUNERAL DIRECTOR  
ADDRESS

712-142 North Ave

VS 150

72084

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Name of deceased                    |  | 2. Sex                                 |  | 3. Age                                 |  |
| 4. Date of death                       |  | 5. Time of death                       |  | 6. Place of death                      |  |
| 7. Cause of death                      |  | 8. Manner of death                     |  | 9. Signature of physician              |  |
| 10. Signature of registrar             |  | 11. Signature of medical examiner      |  | 12. Signature of coroner               |  |
| 13. Signature of funeral director      |  | 14. Signature of undertaker            |  | 15. Signature of cemetery              |  |
| 16. Signature of hospital              |  | 17. Signature of nursing home          |  | 18. Signature of hospice               |  |
| 19. Signature of other institution     |  | 20. Signature of other facility        |  | 21. Signature of other organization    |  |
| 22. Signature of other entity          |  | 23. Signature of other person          |  | 24. Signature of other official        |  |
| 25. Signature of other representative  |  | 26. Signature of other agent           |  | 27. Signature of other representative  |  |
| 28. Signature of other representative  |  | 29. Signature of other representative  |  | 30. Signature of other representative  |  |
| 31. Signature of other representative  |  | 32. Signature of other representative  |  | 33. Signature of other representative  |  |
| 34. Signature of other representative  |  | 35. Signature of other representative  |  | 36. Signature of other representative  |  |
| 37. Signature of other representative  |  | 38. Signature of other representative  |  | 39. Signature of other representative  |  |
| 40. Signature of other representative  |  | 41. Signature of other representative  |  | 42. Signature of other representative  |  |
| 43. Signature of other representative  |  | 44. Signature of other representative  |  | 45. Signature of other representative  |  |
| 46. Signature of other representative  |  | 47. Signature of other representative  |  | 48. Signature of other representative  |  |
| 49. Signature of other representative  |  | 50. Signature of other representative  |  | 51. Signature of other representative  |  |
| 52. Signature of other representative  |  | 53. Signature of other representative  |  | 54. Signature of other representative  |  |
| 55. Signature of other representative  |  | 56. Signature of other representative  |  | 57. Signature of other representative  |  |
| 58. Signature of other representative  |  | 59. Signature of other representative  |  | 60. Signature of other representative  |  |
| 61. Signature of other representative  |  | 62. Signature of other representative  |  | 63. Signature of other representative  |  |
| 64. Signature of other representative  |  | 65. Signature of other representative  |  | 66. Signature of other representative  |  |
| 67. Signature of other representative  |  | 68. Signature of other representative  |  | 69. Signature of other representative  |  |
| 70. Signature of other representative  |  | 71. Signature of other representative  |  | 72. Signature of other representative  |  |
| 73. Signature of other representative  |  | 74. Signature of other representative  |  | 75. Signature of other representative  |  |
| 76. Signature of other representative  |  | 77. Signature of other representative  |  | 78. Signature of other representative  |  |
| 79. Signature of other representative  |  | 80. Signature of other representative  |  | 81. Signature of other representative  |  |
| 82. Signature of other representative  |  | 83. Signature of other representative  |  | 84. Signature of other representative  |  |
| 85. Signature of other representative  |  | 86. Signature of other representative  |  | 87. Signature of other representative  |  |
| 88. Signature of other representative  |  | 89. Signature of other representative  |  | 90. Signature of other representative  |  |
| 91. Signature of other representative  |  | 92. Signature of other representative  |  | 93. Signature of other representative  |  |
| 94. Signature of other representative  |  | 95. Signature of other representative  |  | 96. Signature of other representative  |  |
| 97. Signature of other representative  |  | 98. Signature of other representative  |  | 99. Signature of other representative  |  |
| 100. Signature of other representative |  | 101. Signature of other representative |  | 102. Signature of other representative |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-226  
53 6574

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6574

|   |                              |  |                                    |   |  |
|---|------------------------------|--|------------------------------------|---|--|
| BIRTH NO.   |                              | 1. NAME OF DECEASED<br>(Type or Print) <u>Charles H. Schweizer</u>   |                                    | 2. DATE OF DEATH <u>July 19, 1953</u>                   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY |                                    |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>38 University Hospital</u>  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 5-7-01</u>                |                                    |   |  |
| c. Length of stay in Baltimore  |                              | D. STREET ADDRESS (If rural, give location)<br><u>617 N. Curley St</u>   |                                    |   |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  | 8. DATE OF BIRTH<br><u>11/1/05</u> | 9. AGE (In years last birthday)<br><u>47</u>            | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Asst Lab</u>        |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>McCormick &amp; Co</u>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u> |  |
| 13. FATHER'S NAME<br><u>Henry Schweizer</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?   |                                    |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u> |                              | 16. SOCIAL SECURITY NO.  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Lenastrott</u>           |  |
| 17. INFORMANT<br><u>Hosp. Records</u>   |                              | ADDRESS  |                                    |   |  |

|  |                |                                  |
|--|----------------|----------------------------------|
| 18. <u>421.1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Cerebral embolism</u><br>DUE TO<br><u>2 days</u> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Post operative aortic stenosis</u><br>DUE TO<br><u>20</u>   |                |                                  |

|  |   |  |   |
|--|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  |   |
| 19A. DATE OF OPERATION<br><u>7/16/53</u>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Aortic Stenosis</u>                                | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)                | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

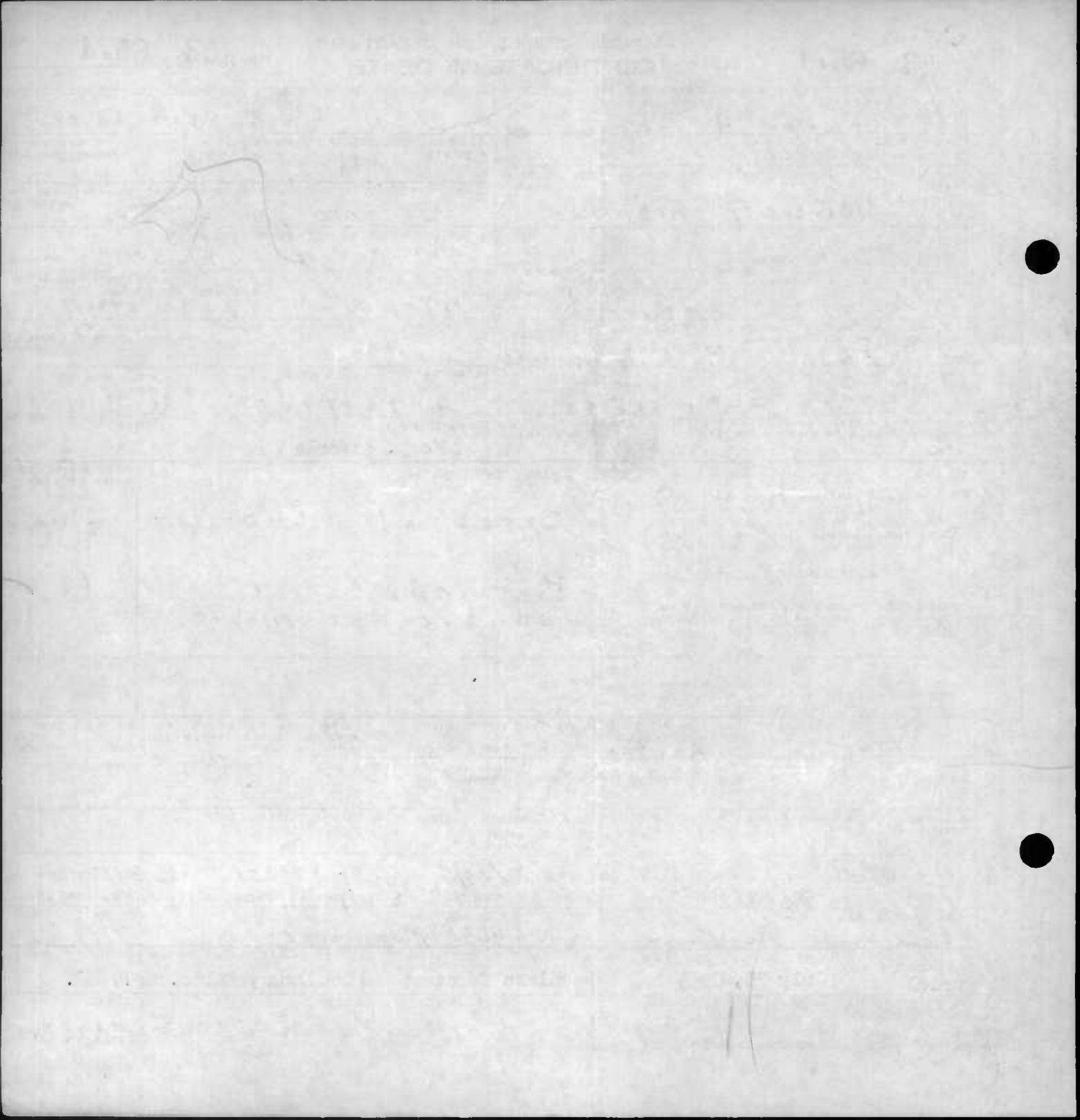
|   |  |  |   |
|---|--|--|---|
| 22. I hereby certify that I attended the deceased from <u>7/19/53</u> , to <u>7/19/53</u> , that I last saw the deceased alive on <u>7/19/53</u> , and that death occurred at <u>8 52</u> m., from the causes and on the date stated above. |  |  |   |
| 23A. SIGNATURE<br><u>Lewis C. Richmond, M.D.</u>  | 23B. ADDRESS<br><u>4630 Manordene Rd.</u>      | 23C. DATE SIGNED<br><u>7/19/53</u>                             |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 24B. DATE<br><u>July 23, 1953</u>              | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u> | 24D. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Balto. Co., Md.</u> |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><u>H. H. Williams</u> | 25. FUNERAL DIRECTOR<br><u>W. V. Vernon</u>                    | ADDRESS<br><u>4611 Park Heights Ave</u>   |

VS 150

09547

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



A-352  
53 6575

## BALTIMORE CITY HEALTH DEPARTMENT

53 6575

Registered No.

TH NO.

## CERTIFICATE OF DEATH

NAME OF DECEASED  
(Last, first, middle, or Print)

CHARLES B ADAMS

2. DATE  
OF  
DEATH

July 18, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

1454 Wicomico ST.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTO

21-02

D. STREET ADDRESS (If rural, give location)

1454 WICOMICO ST.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Aug 7, 1915

9. AGE (In years last birthday)

37

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

USUAL OCCUPATION (Give kind of work during most of working life, even if retired)

BRICKLAYER

10B. KIND OF BUSINESS OR INDUSTRY

Md. Dry Dock

11. BIRTHPLACE (State or foreign country)

DANVILLE, N.Y. U.S.A.

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

CHARLES ADAMS

14. MOTHER'S MAIDEN NAME

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

YES

W. W. Z

16. SOCIAL SECURITY NO.

054-11-4000

17. INFORMANT

ADDRESS

Mrs CHAS B. ADAMS

SAME

18. 198X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Testicle with Metastases 3 months

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Paroplegia, secondary to fracture of spine 5 years

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 14th, 1953, to July 18th, 1953, that I last saw the deceased alive on July 16th, 1953, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Kates MD

M. D.

23B. ADDRESS

517 Scott St.

23C. DATE SIGNED

July 19, 1953.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-21-53

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE NAT'L

24D. LOCATION (City, town, or county)

BALTO. -

(State)

Md

RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

Medred J. Blight

ADDRESS

VS 150

THE HOWARD BLIGHT HOME

6009 Harford Rd. (14)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-460  
53 6576

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6576  
Registered No.

BIRTH NO.

|  |                           |  |   |
|--|---------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Margareth Zeiler</i>   |                           | 2. DATE OF DEATH <i>July 18, 1953</i>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Harford Convalescent Home</i> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-01</i>                                       |   |
| c. Length of stay in Baltimore<br>Yrs. <i>1</i> Mos. <i>1</i> Days <i>1</i>  |                           | D. STREET ADDRESS (If rural, give location)<br><i>4710 Eugene Ave</i>  |   |
| 5. SEX <i>F</i>  | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>   | 8. DATE OF BIRTH <i>Jan-24-1867</i>       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>At Home</i>            |                           | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <i>86</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Bavaria Germany</i>  |                           | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><i>Johanna Weidner</i>  |                           | 14. MOTHER'S MAIDEN NAME<br><i>Margaret</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                 |                           | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><i>Mr. John Zeiler</i>  |                           | ADDRESS<br><i>4710 Eugene Ave</i>  |   |

|  |  |  |
|--|--|--|
| 18. <i>251X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br>(A) <i>Chronic myocarditis</i><br>DUE TO | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 yrs</i> |
|  | (B) <i>Thyroid Hyperactivity</i><br>DUE TO                 |  |
|  | (C) <i>Adenoma Thyroid</i><br>DUE TO                       |  |

|   |  |
|---|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Generalized arteriosclerosis</i> |  |
|---|--|

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION <i>0</i>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from *May 3, 1953*, to *July 18, 1953*, that I last saw the deceased alive on *July 17, 1953*, and that death occurred at *6:06 PM* from the causes and on the date stated above.

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23A. SIGNATURE<br><i>E. V. Harbold</i>                     | M. D.                       | 23B. ADDRESS<br><i>4706 HARFORD Road</i>                   | 23C. DATE SIGNED<br><i>July 18, 1953</i>                             |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i> | 24B. DATE<br><i>7-22-53</i> | 24C. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral</i> | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i> |

|  |   |  |                                   |
|--|---|--|-----------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 20 1953</i> | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>J. H. Smith</i> | ADDRESS<br><i>5305 Harford Rd</i> |
|--|---|--|-----------------------------------|





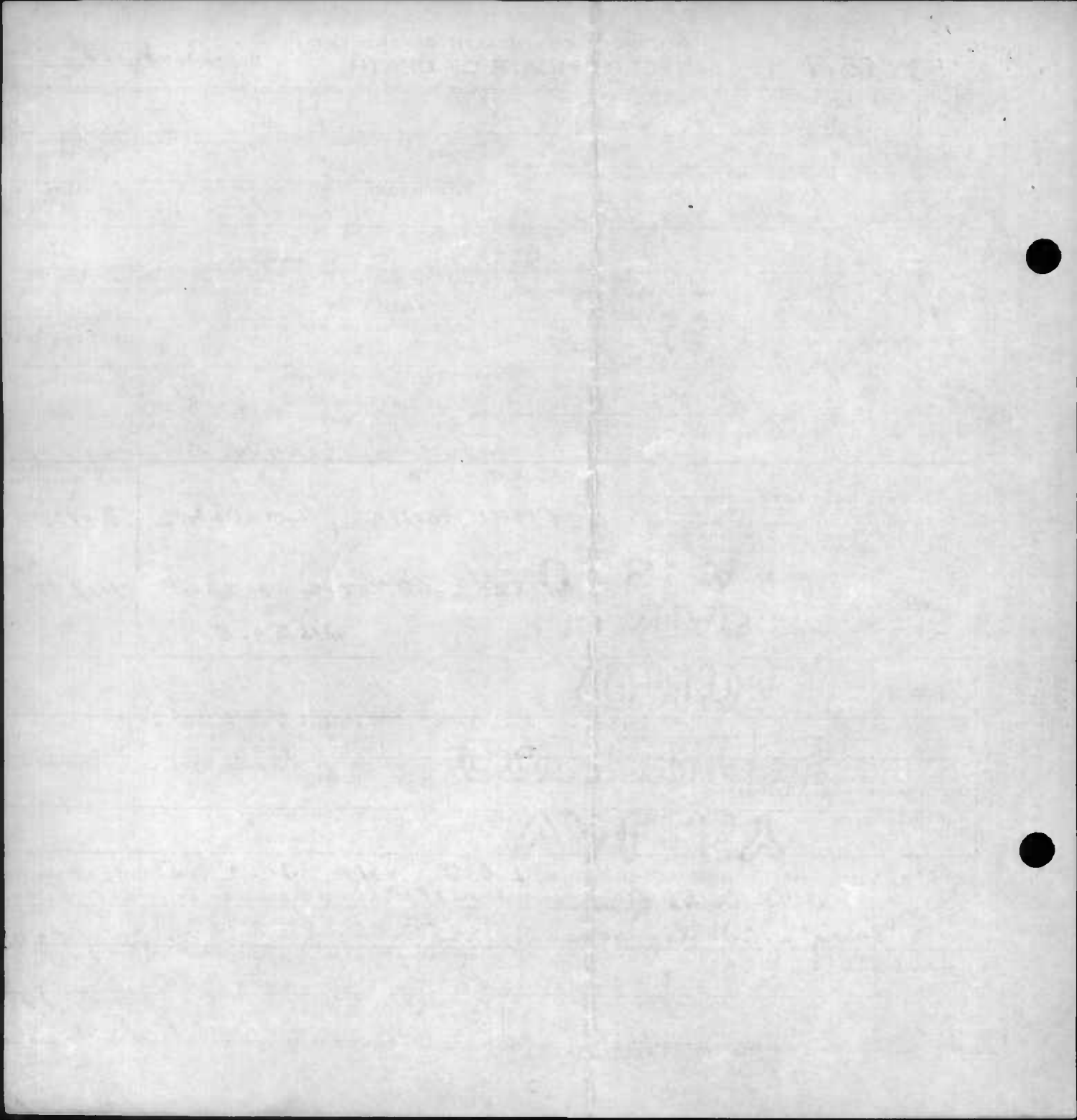
PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| C-652<br>53 6577   |                                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                     | 53 6577<br>Registered No.  |  |
|--|----------------------------------|--|-------------------------------------|--|--|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Emma K. Crunkleton</i>   |                                     | 2. DATE OF DEATH<br><i>7/17/53</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY   |                                     |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Southern Home &amp; Hospital</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. 12-04</i>  |                                     |  |  |
| C. Length of stay in Baltimore<br><i>70</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>301 E. 22<sup>nd</sup> St.</i>   |                                     |  |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>   | 8. DATE OF BIRTH<br><i>6/6/1880</i> | 9. AGE (In years last birthday)<br><i>73</i>   | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Book Keeper</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Alamite Co.</i>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>Pa.</i>  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  | 13. FATHER'S NAME<br><i>John R. Crunkleton</i>   |                                     | 14. MOTHER'S MAIDEN NAME<br><i>Margaret Barnhart</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT<br><i>John R. Crunkleton Jr. 52</i>  |  |
| 18. <i>420.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                                  | CAUSE OF DEATH<br>(A) <i>PNEUMONIA, LOBULAR</i><br>DUE TO<br>(B) <i>ARTEROSCLEROTIC HEART</i><br>DUE TO<br>(C) <i>DISEASE</i>  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 WKS</i><br><i>INDEF.</i>                                      |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                     |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                 |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                     | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                                  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                     | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |                                  | 22. I hereby certify that I attended the deceased from <i>OCT. 1951</i> to <i>JULY 1953</i> , that I last saw the deceased alive on <i>JULY 16, 1953</i> , and that death occurred at <i>11 P.m.</i> , from the causes and on the date stated above. |                                     | 23A. SIGNATURE<br><i>Henry L. Wollanum M.D.</i>  |  |
| 23B. ADDRESS<br><i>225 Medical Arts Bldg.</i>  |                                  | 23C. DATE SIGNED<br><i>July 20, 1953</i>   |                                     | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |
| 24B. DATE<br><i>7/20/53</i>  |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Landon Park</i>   |                                     | 24D. LOCATION (City, town, or county) (State)<br><i>Balto., Md.</i>                                    |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 20 1953</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>H. L. Wollanum, M.D.</i>   |                                     | 25. FUNERAL DIRECTOR<br><i>Wm. Cook Inc.</i>   |  |
| ADDRESS<br><i>1217 St. Paul St.</i>  |                                  |  |                                     |  |  |

VS 150

31024



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-253  
53 6578

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 53 6578  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mr. Francis Lilbourne Schneider

2. DATE  
OF  
DEATH

7-19-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence  
before admission)

A. STATE

Md.

B. COUNTY

BALTIMORE

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give  
township)

HALETHORPE

D. STREET ADDRESS (If rural, give location)

1815 Winans Way,

5200

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10-30-07

9. AGE (In years  
last birthday)

45

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR  
INDUSTRY

WESTERN AUTO

11. BIRTHPLACE (State or foreign country)

Maryland.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Schneider

Dec'd

14. MOTHER'S MAIDEN NAME

Cecelia Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

215-05-3681

17. INFORMANT

ADDRESS

ANNA E. SCHNEIDER 1815 WINANS AVE

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronal embolism  
Myocardial infarction

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 12, 1953 to July 19, 1953 that I last saw the  
deceased alive on July 19, 1953 and that death occurred at 7:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Hevel Ochoe, M.D.

M. O.

23B. ADDRESS

St. Agnes' Hospital

23C. DATE SIGNED

July 19, 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

JULY 23/1953

24C. NAME OF CEMETERY OR CREMATORY

LONDON PARK

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph T. Ambrose 1328 Sulphur Sp. Rd.

3903M

1973

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

WFO 100-100000

10-10-73

Re: [Illegible]

MEMORANDUM

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

M-620  
53 6579BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6579  
Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print)

THOMAS G. MEARS.

2. DATE  
OF  
DEATH

JULY 19, 1963

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3616 WILKINS AVE.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

MARYLAND.

B. COUNTY

C. CITY OR TOWN

BALTIMORE

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3616 WILKINS AVE.

Length of stay in Baltimore LIFE.

SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
MARRIEDYrs.  
Mos.  
Days

8. DATE OF BIRTH

DEC. 25, 1870

9. AGE (In years  
last birthday)

82.

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

PIPE FITTER RETIRED

10B. KIND OF BUSINESS OR  
INDUSTRY

B. &amp; O. R. R.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

ADAMS MEARS.

14. MOTHER'S MAIDEN NAME

EMILY HABBARD.

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ADA V. MEARS. 3616 Wilkins Ave.

18. 156.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma - Liver

Mar. '53

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chronic Myocarditis

1940

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from April 19, 1960, to July 19, 1963, that I last saw the  
deceased alive on July 17, 1963, and that death occurred at 6:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150





MARGIN RESERVED FOR BINDING

PLEASE WRITE PEN ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 6580**

BIRTH NO. **S-632**  
**53 6580**

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William F. Schwartz</b>   |                                  | 2. DATE OF DEATH<br><b>JUL 19 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Med. QAL 6</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>33 JOHNS HOPKINS HOSPITAL</b>        |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 6-02</b>                  |  |
| c. Length of stay in Baltimore <b>LIFE</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2609 FAIRMOUNT AVE.</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>  | 8. DATE OF BIRTH<br><b>3-10-78</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PLUMBING &amp; HEATING CO</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SELF.</b>  | 9. AGE (In years last birthday)<br><b>75</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>FREDERICK SCHWARTZ</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>LEA O'SCHAUSSEY.</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>5422250</b>  |  |
| 17. INFORMANT<br><b>JOHNS HOPKINS HOSPITAL</b>  |                                  | ADDRESS  |  |

|   |  |  |
|---|--|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Chronic Cardiac Disease</b>  |  | <b>Unknown</b>                                     |

|  |   |  |
|--|---|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  |
| 19A. DATE OF OPERATION<br><b>7-19-53</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

|   |   |  |   |
|---|---|--|---|
| 22. I hereby certify that I attended the deceased from <b>7-5-1953</b> to <b>7-19-1953</b> that I last saw the deceased alive on <b>7-19-1953</b> and that death occurred at <b>6:40 A.M.</b> , from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><b>[Signature]</b>  | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>       | 23C. DATE SIGNED<br><b>7/19/53</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 24B. DATE<br><b>JULY 22 1953</b>                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEM</b>                  | 24D. LOCATION (City, town, or county) (State)<br><b>WOODLAWN MD</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 20 1953</b>  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Appel Bros</b> ADDRESS<br><b>7110 BELAIR RD</b> |   |



A-520

53 6581

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6581

Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

Merle Wilson Phenicie

2. DATE  
OF  
DEATH

July 19/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
FAYETTE NURSING HOME

1103 E. Fayette St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 S. Monroe St.

Length of stay in Baltimore 13 yrs.

Yrs.  
Mos.  
Days

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 1, 1918

9. AGE (in years

last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

USUAL OCCUPATION (Give kind of  
business during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR

INDUSTRY

Maryland Dry Dock

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF

WHAT COUNTRY?

FATHER'S NAME

Roy H. Phenicie

14. MOTHER'S MAIDEN NAME

Ethel Yeakle

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

203 10 0628

17. INFORMANT

ADDRESS

Mrs. Thelma Phenicie, 117 S. Monroe St

8. 193X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Astrocytoma

2 yrs

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 18 July, 1953, to 19 July, 1953, that I last saw the  
deceased alive on 8 July, 1953 and that death occurred at 6 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

July 22/53

Sylvan, Pa.

25A. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25B. FUNERAL DIRECTOR

ADDRESS

4101 Edmondson Ave.

VS 150

5443U

1951

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

1951



N-452

53 6582

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6582

TH NO.

NAME OF DECEASED  
(or Print)

MARGARET ELLEN WILLIAMS

2. DATE  
OF  
DEATH

7/18/53

PLACE OF DEATH:

Baltimore City, Maryland Union Memorial Hosp.

FULL NAME OF (If not in hospital or institution, give street address or location)

Union Memorial Hospital

57 Yrs. Mos. Days

length of stay in Baltimore

EX

MALE WHITE

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

10B. KIND OF BUSINESS OR INDUSTRY

own home

FATHER'S NAME

Thomas J. German

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

8. 224X

1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Transverse intracranial

DUE TO

(B) Pituitary Tumor

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

7/17

19B. MAJOR FINDINGS OF OPERATION

Pituitary Tumor

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I hereby certify, that I attended the deceased from July 16, 1953, to July 18, 1953, that I last saw the deceased alive on July 18, 1953, and that death occurred at 2:01 A.M., from the causes and on the date stated above.

3A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Huntington Williams, M.D.

5/20

RECEIVED  
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W-452  
53 6583BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6583

Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

LUTHER WILLIAMS

2. DATE  
OF  
DEATH

7/18/53

PLACE OF DEATH:

Baltimore City, Maryland *Balts. City*FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

MERCY HOSP. INC.

Length of stay in Baltimore

LIFE

SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

2-5-1879

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Steamer operator

10b. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

ISSACS WILLIAMS

14. MOTHER'S MAIDEN NAME

ANNIE FORESTER

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

WIFE

ADDRESS

ABOVE

B. 151X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) CARCINOMA OF STOMACH

DUE TO

&gt; 3 mo

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE. (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

JULY 14, 53

19b. MAJOR FINDINGS OF OPERATION

CARCINOMA STOMACH

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
P. M.

21e. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from 7/15/53, 1953, to 7/18/53, 1953, that I last saw the  
deceased alive on 7/18, 1953, and that death occurred at 3 P.m., from the causes and on the date stated above.

23a. SIGNATURE

Thomas Courtney

M. D.

23b. ADDRESS

MERCY HOSPITAL

23c. DATE SIGNED

7/18/53

BURIAL, CREMA-  
TION (Specify)

24b. DATE

7/22/53

24c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24d. LOCATION (City, town, or county)

Baltimore, MD

(State)

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. H. Williams

25. FUNERAL DIRECTOR

H. H. Williams &amp; Wilson 1000 Broadway

ADDRESS

VS 150

76174

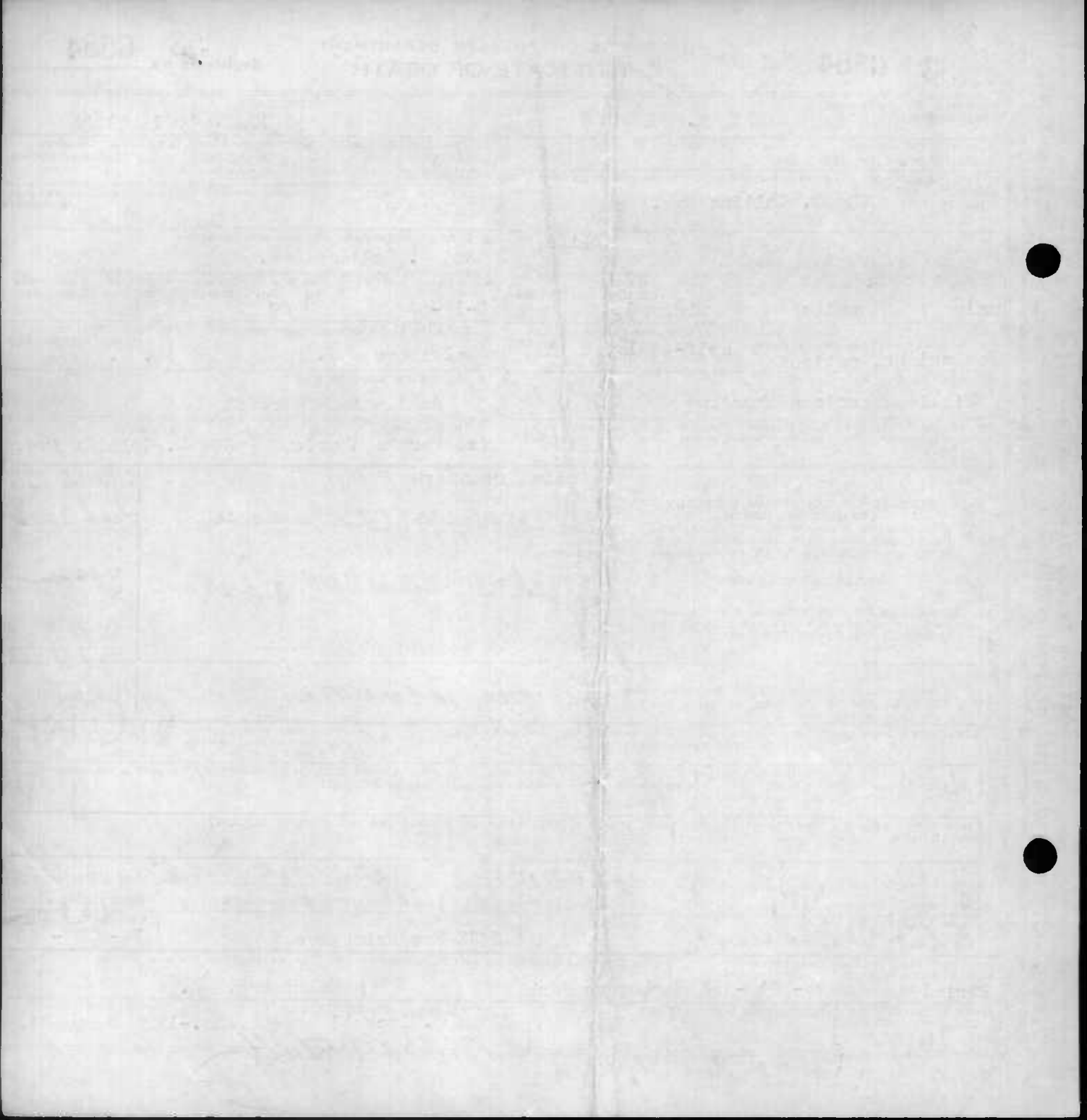
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH AND SAFETY  
BUREAU OF ENVIRONMENTAL HEALTH SERVICES  
NATIONAL TOXICOLOGY PROGRAM

| IDENTIFICATION |                      | TESTING      |            | RESULTS     |                     |
|----------------|----------------------|--------------|------------|-------------|---------------------|
| TEST NO.       | TEST NAME            | TEST TYPE    | TEST DATE  | TEST RESULT | TEST COMMENT        |
| 1              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 2              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 3              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 4              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 5              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 6              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 7              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 8              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 9              | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |
| 10             | 1,2-DIBENZO-A-PYRENE | GENOTOXICITY | 1990-01-10 | POSITIVE    | See attached report |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| <p style="font-size: 2em; margin: 0;">J-640</p> <p style="font-size: 1.5em; margin: 0;">53 6584</p>  |                                  | <p style="font-weight: bold; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-weight: bold; margin: 0;">CERTIFICATE OF DEATH</p> |  | <p style="font-size: 1.5em; margin: 0;">53 6584</p> <p style="margin: 0;">Registered No. _____</p> |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HARRY D. THURLOW</b>   |                                  |   | 2. DATE OF DEATH <b>July 18, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>304 S. Collins Ave.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |   |
| c. Length of stay in Baltimore <b>life</b> Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>304 S. Collins Ave.</b>  |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>   | 8. DATE OF BIRTH<br><b>7-18-53</b>   | 9. AGE (In years last birthday)<br><b>67</b>   | <div style="display: flex; justify-content: space-between;"> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>Bookseller, retired</b></div> <div>11. BIRTHPLACE (State or foreign country)<br/><b>Baltimore, Md.</b></div> </div> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookseller, retired</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |   |
| 13. FATHER'S NAME<br><b>William Harrison Thurlow</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Ann DeGrofft</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Miss Martha Thurlow 304 S. Collins Ave.</b>  |  |   |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion</b><br>DUE TO<br><b>Coronary Vascular Disease</b><br>DUE TO<br><b>Coronary Thrombosis</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>3 years</b><br><b>11/4/50</b>  |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |  |  |   |
| 19A. DATE OF OPERATION <b>0</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                             |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                           |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>11/4</b> , 19 <b>50</b> , to <b>7/18</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>11/7</b> , 19 <b>53</b> , and that death occurred at <b>11:00</b> m., from the causes and on the date stated above.   |                                  |   |  |  |   |
| 23A. SIGNATURE<br><b>E. J. W. Jackson</b>  |                                  | 23B. ADDRESS<br><b>3432 Frederick Ave.</b>  |  | 23C. DATE SIGNED<br><b>7-20-53</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>7-21-53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                                  | 25. FUNERAL DIRECTOR<br><b>John O. Mitchell &amp; Sons, Inc.-1900 Eutaw Pl.</b>   |  |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 20 1953</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  | ADDRESS<br><b>2906U</b>  |   |



5-253  
53 6585

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6585

NAME OF DECEASED (Last, first, and middle name or Print) **Marian E. Schmidt**

2. DATE OF DEATH **July 18/53**

PLACE OF DEATH: **Baltimore City, Maryland**

3. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) **152 S. Culver St.**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **Md.**  
B. COUNTY **20-07**

5. LENGTH OF STAY IN BALTIMORE **Life**

6. COLOR OR RACE **White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Sept. 27/97**

9. AGE (in years last birthday) **55**

10. KIND OF BUSINESS OR INDUSTRY **Own Home**

11. BIRTHPLACE (State or foreign country) **Balto. Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Andrew Plum**

14. MOTHER'S MAIDEN NAME **Tenie Pencek**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Vernon P. Schmidt, 152 S. Culver St**

18. ADDRESS

19. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Cerebral Vascular Accident 8 hrs**  
DUE TO  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**Cerebral Thrombosis**  
DUE TO  
**Possible embolus**  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**Thrombophlebitis, right femoral vein**

20. INTERVAL BETWEEN ONSET AND DEATH **One year**

21. DATE OF OPERATION **0**

22. MAJOR FINDINGS OF OPERATION

23. AUTOPSY? YES ☐ NO ☐

24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

25. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

27. TIME (Month) (Day) (Year) OF INJURY

28. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

29. HOW DID INJURY OCCUR?

30. I hereby certify that I attended the deceased from **July 17, 1953** to **July 19, 1953** that I last saw the deceased alive on **July 19, 1953** and that death occurred at **11:45 a.m.**, from the causes and on the date stated above.

31. SIGNATURE **Herbert W. Laph**

32. ADDRESS **3321 Frederick Ave**

33. DATE SIGNED **July 20, 53**

34. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

35. DATE **July 21/53**

36. NAME OF CEMETERY OR CREMATORY **Loudon Park**

37. LOCATION (City, town, or county) (State) **Baltimore, Md.**

38. RECEIVED BY **Dr. Harry H. Smith**

39. REGISTRAR'S SIGNATURE **Harry H. Smith**

40. FUNERAL DIRECTOR **4101 Edmondson Ave.**

41. ADDRESS

VS 150

UNITED STATES DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE  
OFFICE OF THE MARITIME COMMISSIONER

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H-520  
53 6586BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6586

TH NO.

NAME OF DECEASED  
(Last name or Print)

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF

HOSPITAL OR

INSTITUTION

Length of stay in Baltimore

SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Florist

10a. KIND OF BUSINESS OR  
INDUSTRY

Own Business

FATHER'S NAME

Adolph Hinz

HAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.2. DATE  
OF  
DEATH

7-19-53

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
Illinois

B. COUNTY

V-11

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

-Elmhurst

D. STREET ADDRESS (If rural, give location)

470 Larch Ave

8. DATE OF BIRTH

May 6, 1900 53

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Sophie WITTE

17. INFORMANT

ADDRESS

3. 584X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

Acute Gangrenous Cholecystitis  
and Cholelithiasis

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

7-17-53

19b. MAJOR FINDINGS OF OPERATION

Acute Gangrenous Cholecystitis &amp; Cholelithiasis

20. AUTOPSY?

YES ☒ NO ☐11A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

11D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from 7-17-53, 1953, to 7-19-53, 1953 that I last saw the  
deceased alive on 7-19-53, 1953 and that death occurred at 5:00 P.M., from the causes and on the date stated above.

3. SIGNATURE

Dr. Donald Lasher

M. D.

23B. ADDRESS

Md. Emblem Hosp.

23C. DATE SIGNED

7-19-53

BURIAL CREMA-  
TIONAL (Specify)

Removal

24B. DATE

7/20/53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Emblem Cem.

24D. LOCATION (City, town, or county)

Elmhurst, Ill.

(State)

RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Chas. J. Tiekner &amp; Sons

ADDRESS

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Balto 17, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|  |                           |  |                                   |  |   |
|--|---------------------------|--|-----------------------------------|--|---|
| No-4205<br>53 6587   |                           | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                   | 53 6587<br>Registered No.  |   |
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print)   |                                   | 2. DATE OF DEATH   |   |
|  |                           | JOHN E. HILTNER, SR.   |                                   | July 17, 1953  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md. |                                   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Lutheran Hosp.  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-04          |                                   |  |   |
| c. Length of stay in Baltimore   |                           | D. STREET ADDRESS (If rural, give location)<br>2121 Ridgehill Ave.                                       |                                   |  |   |
| 5. SEX<br>male   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married   | 8. DATE OF BIRTH<br>Nov. 22, 1887 | 9. AGE (In years last birthday)<br>65                                    | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Clerk   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Bureau Highways Balto. City   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |   |
| 13. FATHER'S NAME<br>Charles J. Hiltner  |                           | 14. MOTHER'S MAIDEN NAME<br>Florence K. Bosheimer  |                                   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>no   |                           | 16. SOCIAL SECURITY NO.<br>218-05-5364   |                                   | 17. INFORMANT ADDRESS<br>Mrs. Mildred I. Hiltner-2121 Ridgehill Av       |   |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO<br>CORONARY THROMBOSIS<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>CHRONIC ARTERIO-SCLEROTIC ANDIO-VASCULAR DISEASE<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           | CAUSE OF DEATH   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 19A. DATE OF OPERATION   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |                                   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from May 12, 1953, to July 10, 1953, that I last saw the deceased alive on July 10, 1953, and that death occurred at 9:30 P.m., from the causes and on the date stated above.  |                           |  |                                   |  |   |
| 23A. SIGNATURE<br>D. C. Laughlin   |                           | 23B. ADDRESS<br>M. D. 4508 Edmondson Village   |                                   | 23C. DATE SIGNED<br>7/20/53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 24B. DATE<br>7/21/53   |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.                 |   |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.  |                           | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br>20 1953   |                                   | 24F. REGISTRAR'S SIGNATURE<br>Huntington Williams                        |   |
| 24G. FUNERAL DIRECTOR'S ADDRESS<br>20 1953   |                           | 24H. FUNERAL DIRECTOR'S SIGNATURE<br>Wm. J. Dickner & Sons   |                                   | 24I. BALTO. 17, MD.  |   |

SECRET 122

SECRET

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6588  
Registered No.

53 658853-06186  
BIRTH NO.

|  |                                  |  |  |  |   |
|--|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JERRY LYN SISLER</b>   |                                  |  | 2. DATE OF DEATH<br><b>July 19, 1953</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>                                    |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |   |
| c. Length of stay in Baltimore   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>3140 Elliott</b>   |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>March 10 1953</b>   |  | 9. AGE (In years last birthday)<br><b>4</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |  | 12. CITIZEN OF WHAT COUNTRY?                |
| 13. FATHER'S NAME<br><b>Stanley P. Sisler</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lou Anna Shafer</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS <input checked="" type="checkbox"/>  |  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>571.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Dehydration</b><br>DUE TO <b>acute gastro-enteritis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO  |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |  |  |  |   |
|--|--|--|--|---|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |
| 23A. SIGNATURE<br><i>R. J. Fisher</i>  |  | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....  |  | 23C. DATE SIGNED<br><b>7-20-53</b>  |

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 21st 1953</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Brendowville W. Va.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>322 S. High St.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>III 20 1953</b>     |                                    | REGISTRAR'S SIGNATURE<br><i>Frank Della Valle</i>                |   |

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BE APPROVED BY THE MEDICAL EXAMINER  
BALTIMORE CITY HEALTH DEPARTMENT  
53. 6589  
CERTIFICATE OF DEATH

Registered No. 53. 6589

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)<br><b>Testa, Anthony</b>   |  | 2. DATE OF DEATH<br><b>July 19, 1953</b>  |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location) <b>748 Poplar Grove Street</b> |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>St. Joseph's</b>  |  | 6. COLOR OR RACE <b>W.</b>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |  | 8. DATE OF BIRTH<br><b>Feb 21st 1859</b>  |  |
| 9. AGE (In years, last birthday)<br><b>94</b>   |  | 10. AGE (In years, last birthday)<br><b>4</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Italy</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. MOTHER'S MAIDEN NAME<br><b>Giacetta Martini</b>   |  | 14. MOTHER'S MAIDEN NAME  |  |
| 15. FATHER'S NAME<br><b>Giuseppe Testa</b>  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Anthony D'Amico</b>   |  | ADDRESS <b>8304 Liberty Rd.</b>   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give war or dates of service)   |  | 19. CAUSE OF DEATH  |  |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>491X and E903.0</b>                                    |  | 21. INTERVAL BETWEEN ONSET AND DEATH  |  |
| 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Fracture femur, right</b>   |  | 23. CERTIFICATION APPROVED BY<br><b>R. F. Fisher</b><br>CHIEF OR ASST. MEDICAL EXAMINER   |  |
| 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | 25. DATE OF OPERATION<br><b>July 17, 1953</b>   |  |
| 26. MAJOR FINDINGS OF OPERATION<br><b>Fracture femur, right</b>   |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>  |  | 29. WHERE DID INJURY OCCUR?<br><b>748 Poplar Grove Street</b>   |  |
| 30. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>7-12-53</b>  |  | 31. HOW DID INJURY OCCUR?<br><b>slipped and fell to floor</b>   |  |
| 32. I hereby certify that I attended the deceased from <b>July 12, 1953</b> to <b>July 19, 1953</b> , that I last saw the deceased alive on <b>July 19, 1953</b> , and that death occurred at <b>12:15 p.m.</b> , from the causes and on the date stated above. |  | 33. SIGNATURE<br><b>Alagio E. Layman</b>  |  |
| 34. ADDRESS<br><b>1100 N. Caroline Street</b>   |  | 35. DATE SIGNED<br><b>July 19, 1953</b>   |  |
| 36. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 37. DATE<br><b>July 23 1953</b>   |  |
| 38. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |  | 39. LOCATION (City, town, or county)<br><b>Baltimore Md.</b>  |  |
| 40. RECEIVED BY<br><b>Huntington</b>  |  | 41. REGISTRAR'S SIGNATURE<br><b>Huntington</b>  |  |
| 42. FUNERAL DIRECTOR<br><b>St. Ann's Della Noce</b>   |  | 43. ADDRESS<br><b>322 S. High St.</b>   |  |

5

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH BROSTEK BRZOSTEK

2. DATE  
OF  
DEATH

July 17/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland City Jail

B. FULL NAME OF (If not in hospital or institution, give street address or location)

801 Buren ST

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1-03

D. STREET ADDRESS (If rural, give location)

505 S. Patterson Park Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 1915 38

9. AGE (In years last birthday)

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trucker

10B. KIND OF BUSINESS OR INDUSTRY

Transfer Co.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Kasper Brzostek

14. MOTHER'S MAIDEN NAME

Julia Hagnabski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

220038338

17. INFORMANT

Kasper Brzostek

ADDRESS

18. 353.3

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

EPILEPTIC SEIZURES

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

CARDIAC HYPERTROPHY AND DILATATION

(C) DUE TO

FATTY METAMORPHOSIS OF LIVER

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

7-18-53

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

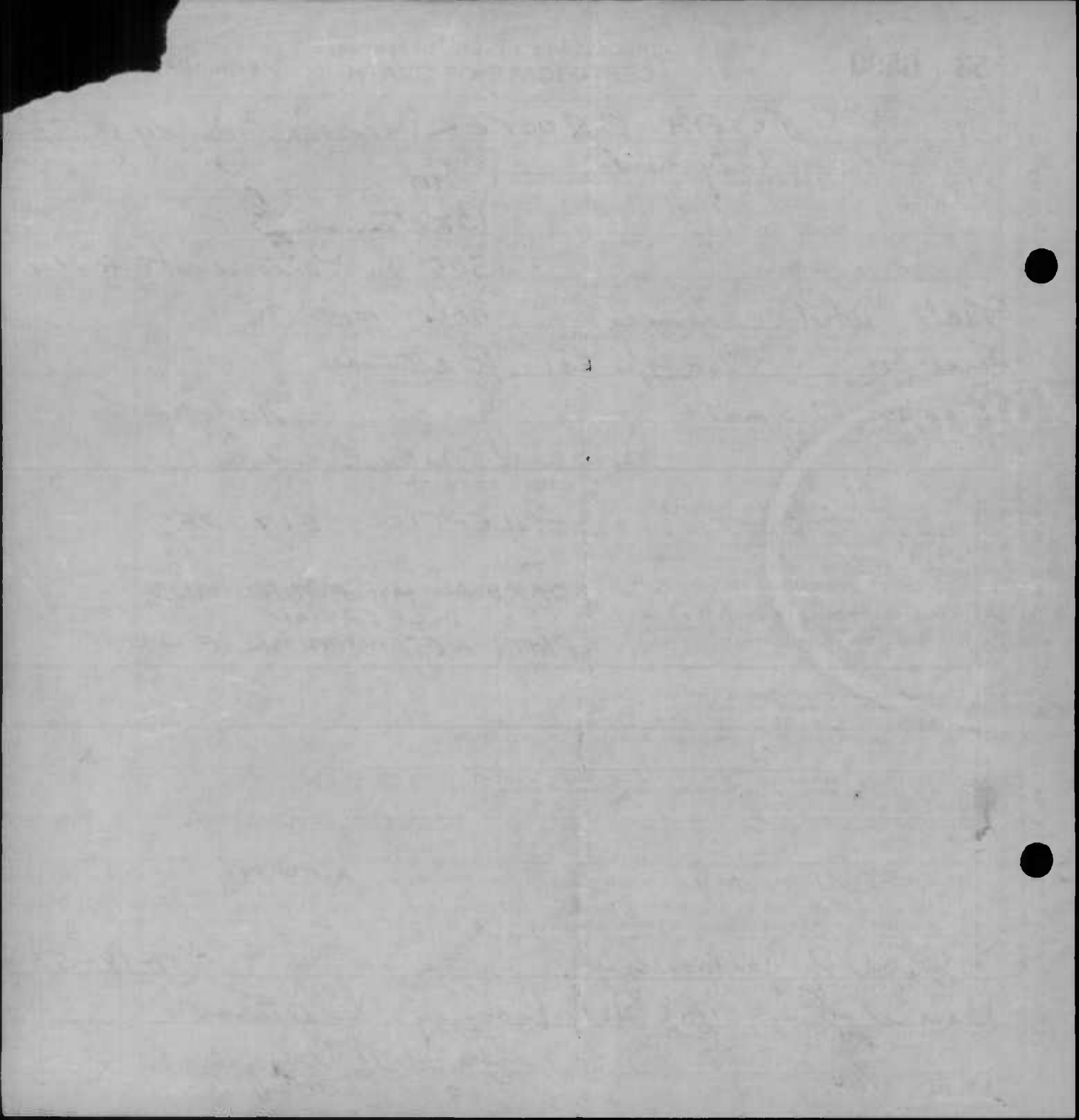
25. FUNERAL DIRECTOR

ADDRESS

Burlington

Fried W. Ozazewski

68352 1930 E. Baltimore Ave



PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W-320

53 6591

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6591

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward Watts Jr.

2. DATE  
OF  
DEATH

July 19 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Hotel

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Ind.

B. COUNTY

Barre

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Sylmarville

D. STREET ADDRESS (If rural, give location)

Rt 2

5600

c. Length of stay in Baltimore

10

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year Months: Days  
11 Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

no

no

215-05-3369

JOHNS HOPKINS HOSPITAL

18. 193x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...  
DUE TO

Right frontal  
glioma

3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...  
DUE TO

(C) ...

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Rt frontal craniotomy 7.16.53

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/9, 1953, to 7/19, 1953 that I last saw the deceased alive on 7/19, 1953 and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

20m Queen M. D.

JOHNS HOPKINS HOSPITAL

7.19.53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

7/21/53

Druid Ridge Pikesville, Md.

Huntington Williams M.D.

Frank H. Newell - Pikesville Md.

JUL 20 1953

450 73





W-200  
53 6592BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6592  
Registered No.

BIRTH NO.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mrs. Carrie Wise</b>  |                                  |   | 2. DATE OF DEATH<br><b>7-19-53</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>BALTIMORE</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore HALETHORPE 5309</b>                        |  |   |
| c. Length of stay in Baltimore <b>3 days</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>4713 Washington Blvd.</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>3-31-1887</b>  |  | 9. AGE (In years last birthday) <b>66</b>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |
| 13. FATHER'S NAME<br><b>Chenoweth (Deceased)</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Toy (Deceased)</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  | 17. INFORMANT<br><b>ALBERT L. WISE</b>  |  |   |
| 18. <b>151X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Stomach cancer with gen. metastases.</b> |                                  |   | ADDRESS<br><b>4713 Washington Blvd.</b>   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>July 17, 1953</b> to <b>July 19, 1953</b> that I last saw the deceased alive on <b>July 18, 1953</b> , and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above.      |                                  |   |   |  |   |
| 23A. SIGNATURE<br><b>Henry Ochotz, M.D.</b>   |                                  |   | 23B. ADDRESS<br><b>St. Agnes Hospital</b>   |  | 23C. DATE SIGNED<br><b>July 19, 53</b>                                |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 24B. DATE<br><b>7-21-53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |   | 25. FUNERAL DIRECTOR<br><b>George L. Schwab</b>                          |   |
|   |                                  |   |   | ADDRESS<br><b>2101 Frederick Ave.</b>                                    |   |

503 80

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

TERESA RUPPEL

2. DATE  
OF  
DEATH

July 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

836 Hillman Court

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

836 Hillman Court

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Feb. 17, 1873

9. AGE (In years  
last birthday)

80

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Paper Box Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Anton Ruppel

14. MOTHER'S MAIDEN NAME

Mary Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Wm. P. Chew-1617 Park Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Anterior Wall Cardio Vascular Disease

app 2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 May, 1962, to 16 July, 1963, that I last saw the  
deceased alive on 19 July, 1963, and that death occurred at 40 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

1513 N. Milford Ave

23C. DATE SIGNED

20 July 63

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tichenor &amp; Sons

Balto., Md.

WOMEN  
COMMITTEE  
AMERICA

3-615

GRIFFIN

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6594

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Griffin, Virginia Frances

2. DATE  
OF  
DEATH

July 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Home for Incurables, 700 W. 40th St

C. Length of stay in Baltimore

36 yrs.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Apr. 8, 1907

9. AGE (In years  
last birthday)

46 yrs.

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

None.

13. FATHER'S NAME

James Frances Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

Yes, no or unknown)

No.

16. SOCIAL  
SECURITY NO.

14. MOTHER'S MAIDEN NAME

Sarah Jane Carey

17. INFORMANT

ADDRESS

Mary E. Edmonston, Home for Incurables

18. 443X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

Hypertensive Cardio-  
vascular Disease

(B)

DUE TO

Kyphosis

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.INTERVAL BETWEEN  
ONSET AND DEATH

3 1/2 hrs

4 years?

35 yrs

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

22. I hereby certify that I attended the deceased from June 21, 1953, to July 20, 1953 that I last saw the deceased alive on July 20, 1953 and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

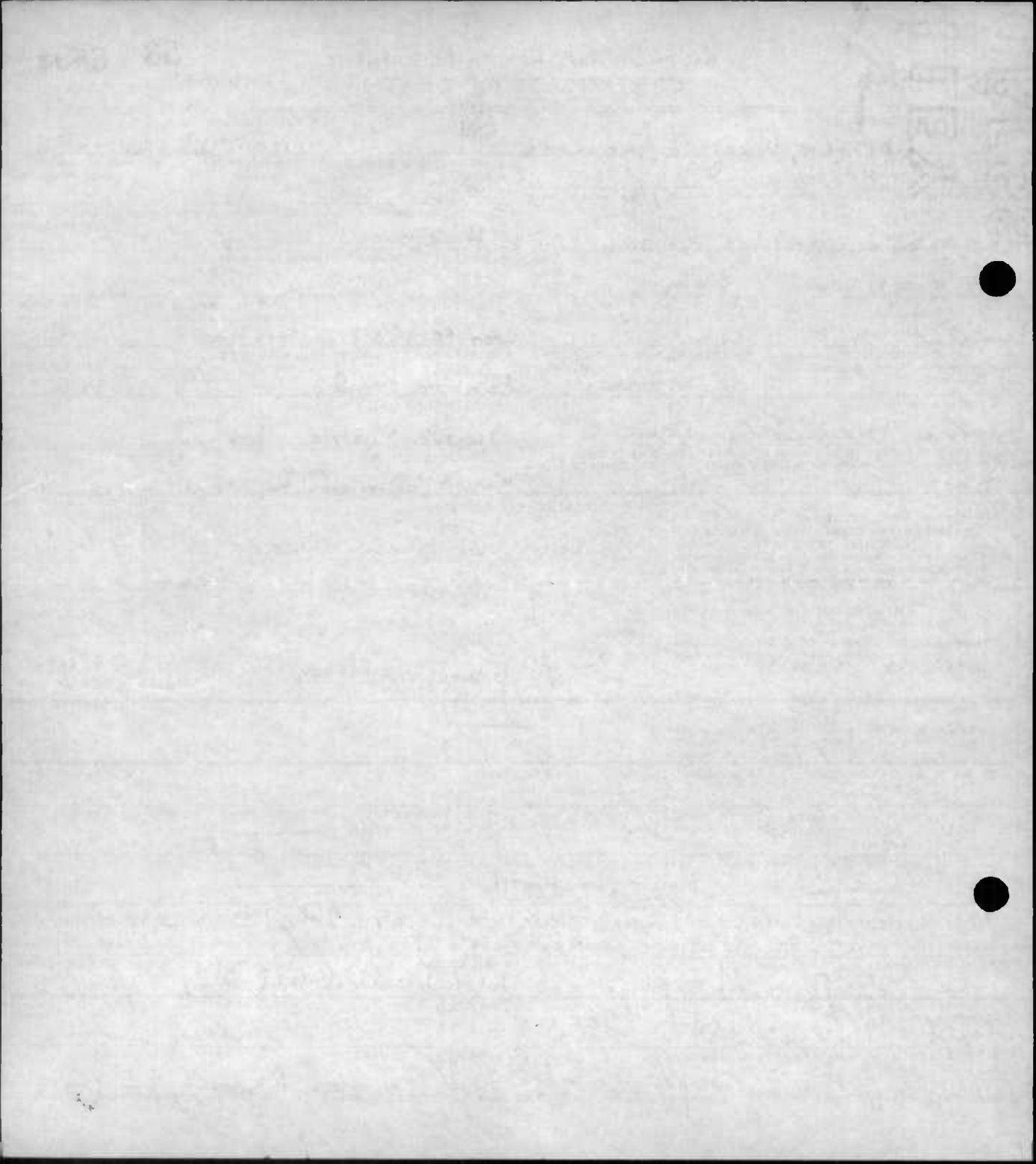
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 21 1953

VS 150





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 53 6595  
Registered No.

|  |                                  |  |   |  |                               |
|--|----------------------------------|--|---|--|-------------------------------|
| F-420<br>53 6595<br>BIRTH NO.  |                                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |   | X 53 6595<br>Registered No.  |                               |
| 1. NAME OF DECEASED<br>(Type or Print) <i>John Pollack</i>   |                                  |  | 2. DATE OF DEATH <i>July 20, 1953</i>   |  |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>John Bui 3</i>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>W. Va.</i> B. COUNTY <i>V-45</i> |  |                               |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                  |  | C. CITY OR TOWN <i>Rachel</i><br>D. STREET ADDRESS (If rural, give location)  |  |                               |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  |  |   |  |                               |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>                                      | 8. DATE OF BIRTH<br><i>4-16-16</i>  | 9. AGE (In years last birthday)<br><i>37</i>                             | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Coal Miner</i>   |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |                               |
| 11. BIRTHPLACE (State or foreign country)<br><i>Pa.</i>  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |                               |
| 13. FATHER'S NAME<br><i>Charles Pollack</i>  |                                  |  | 14. MOTHER'S MAIDEN NAME  |  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>  |                                  |  | 16. SOCIAL SECURITY NO.   |  |                               |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                  |  | ADDRESS   |  |                               |
| 18. <i>016X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Uremia</i><br>DUE TO    |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr</i>   |  |                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Renal Tuberculosis</i><br>DUE TO  |                                  |  | <i>8 yrs</i>  |  |                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |  |   |  |                               |
| 19A. DATE OF OPERATION<br><i>7</i>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |                               |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |  |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |                               |
| 22. I hereby certify that I attended the deceased from <i>6-28-1953</i> to <i>7-20-1953</i> , that I last saw the deceased alive on <i>7-20-1953</i> and that death occurred at <i>3:45 P.M.</i> , from the causes and on the date stated above. |                                  |  |   |  |                               |
| 23A. SIGNATURE<br><i>William A. Campbell M. D.</i>   |                                  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |   | 23C. DATE SIGNED<br><i>7-20-53</i>                                       |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 24B. DATE<br><i>July 23, 1953</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mannington Cemetery</i>         |                               |
| 24D. LOCATION (City, town, or county) (State)<br><i>Mannington West Virginia</i>   |                                  |  |   |  |                               |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 21 1953</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>  |   | 25. FUNERAL DIRECTOR<br><i>Henry Sander &amp; Sons Inc.</i>              |                               |
| VS 150   |                                  | Baltimore Md.  |   | <i>George J. Sander</i>  |                               |

65021

CERTIFICATE OF DEATH

Registration No.

8-10

|                  |  |                  |  |                |  |               |  |                |  |
|------------------|--|------------------|--|----------------|--|---------------|--|----------------|--|
| Name of Deceased |  | Sex              |  | Age            |  | Date of Birth |  | Place of Birth |  |
| John Doe         |  | Male             |  | 45             |  | 10-10-1875    |  | New York City  |  |
| Usual Residence  |  | Occupation       |  | Cause of Death |  | Date of Death |  | Place of Death |  |
| 123 Main St.     |  | Teacher          |  | Heart Disease  |  | 10-20-1920    |  | Home           |  |
| Physician        |  | Medical Examiner |  | Coroner        |  | Burial Place  |  | Burial Date    |  |
| Dr. Smith        |  | J. Doe           |  | A. Doe         |  | Cemetery      |  | 10-25-1920     |  |

CAUSE OF DEATH

|                 |  |                         |  |                  |  |
|-----------------|--|-------------------------|--|------------------|--|
| Immediate Cause |  | Intermediate Cause      |  | Underlying Cause |  |
| Heart Failure   |  | Coronary Artery Disease |  | Hypertension     |  |
| Symptoms        |  | Diagnosis               |  | Treatment        |  |
| Chest Pain      |  | Myocardial Infarction   |  | Medicine         |  |

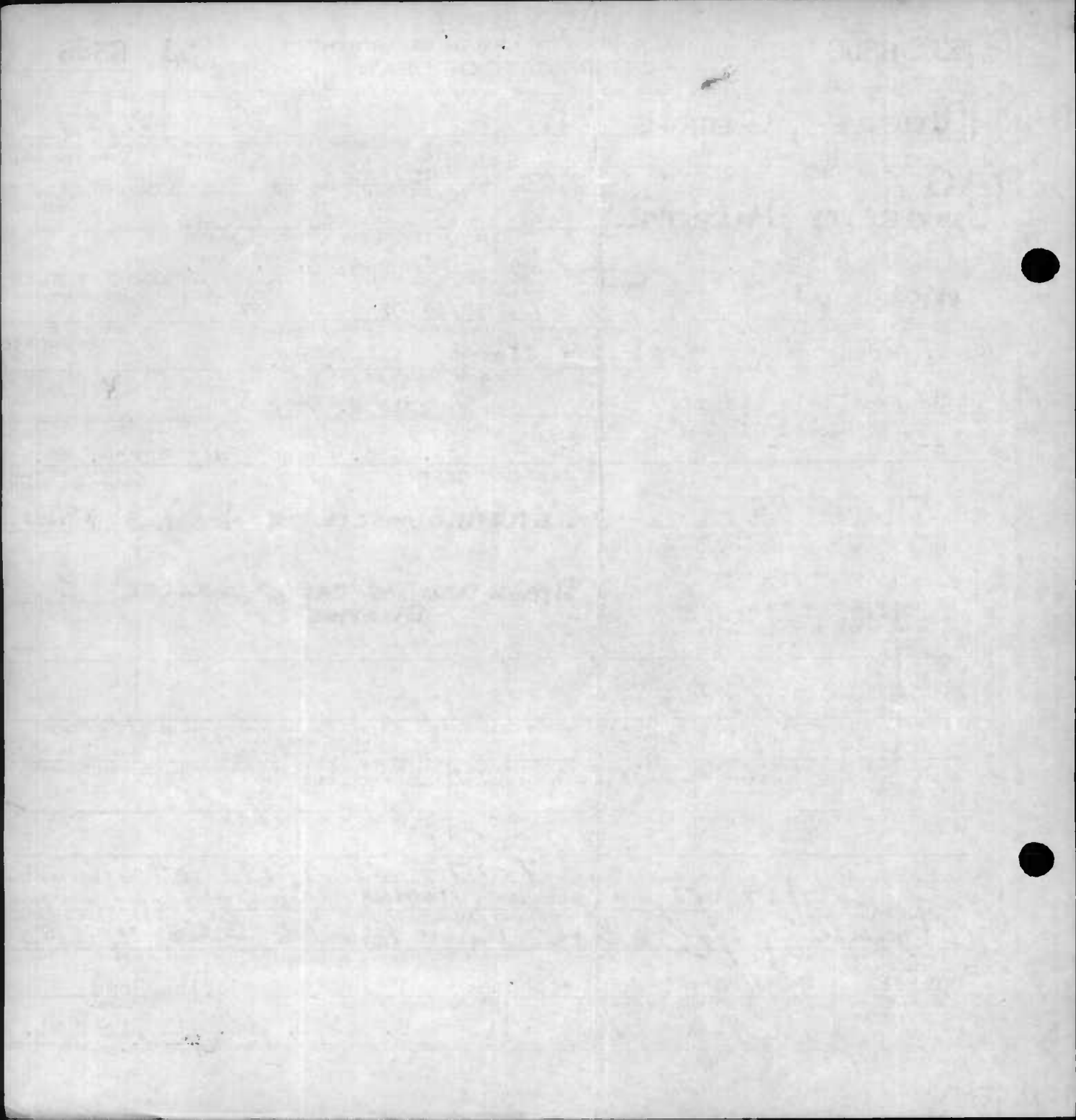
|                        |  |                               |  |                      |  |
|------------------------|--|-------------------------------|--|----------------------|--|
| Signature of Physician |  | Signature of Medical Examiner |  | Signature of Coroner |  |
| [Signature]            |  | [Signature]                   |  | [Signature]          |  |
| Date                   |  | Time                          |  | Place                |  |
| 10-20-1920             |  | 10:00 AM                      |  | Home                 |  |

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| BIRTH NO.  |                              | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | Registered No. 53 6586  |  |
|--|------------------------------|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>LEESE, GEORGE H.</b>  |                              |  | 2. DATE OF DEATH<br><b>7/19/53</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland<br>B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>UNIVERSITY HOSPITAL</b><br>C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>Maryland</b><br>B. COUNTY<br><b>Anne Arundel</b><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Lake Shore 5200</b><br>D. STREET ADDRESS (If rural, give location)<br><b>Pasadena, P. O., Md.</b> |   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH<br><b>10/31/05</b>  | 9. AGE (In years last birthday)<br><b>47</b>                                | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supt. Warehouse</b>  |                              |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing-Supplies</b>  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |                              |  | 12. CITIZEN OF WHAT COUNTRY?   |   |  |
| 13. FATHER'S NAME<br><b>George Lewis Leese</b>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>Carrie M. Spicer</b>  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                              |  | 16. SOCIAL SECURITY NO.<br><b>215-05-2262</b>  |   |  |
| 17. INFORMANT<br><b>Mrs. Geo. Leese</b>  |                              |  | ADDRESS<br><b>Lake Shore, Md.</b>  |   |  |
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CEREBROVASCULAR Accident</b><br>DUE TO<br><b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b> |                              |  |  |   |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>DUE TO<br>DUE TO   |                              |  |  |   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                              |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                              | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                              | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>7-17</b> , 19 <b>53</b> , to <b>7/19</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7/19</b> , 19 <b>53</b> , and that death occurred at <b>12:01 AM</b> from the causes and on the date stated above.  |                              |  |  |   |  |
| 23A. SIGNATURE<br><b>Frank G. Reehm, D.</b>  |                              | 23B. ADDRESS<br><b>Univ. Hospital Balto.</b>   |  | 23C. DATE SIGNED<br><b>7/19/53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 24B. DATE<br><b>7/22/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                  |  |
| 24D. LOCATION (City, town, or county)<br><b>Old Frederick Road</b>   |                              | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 21 1953</b>  |  |   |  |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |                              | 25. FUNERAL DIRECTOR<br><b>JOHN F. DENNY, INC.</b>   |  | ADDRESS<br><b>715 Light St.</b>   |  |

29053



|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 445  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 53 6597  |  |
| 3 6597   |  | CERTIFICATE OF DEATH   |  | Registered No.   |  |
| NAME OF DECEASED (Last, first, middle initial, or Print)   |  | EMMA WILHELM   |  | 2. DATE OF DEATH 7/18/53   |  |
| PLACE OF DEATH: Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  | A. STATE MARYLAND  |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                           |  | B. COUNTY BALTIMORE 26-11  |  |
| HOSPITAL OR INSTITUTION SINAI HOSPITAL INC.  |  | D. STREET ADDRESS (If rural, give location)  |  | 928 S. CLINTON STREET  |  |
| Age of stay in Baltimore 71 YRS  |  | Yrs. Mos. Days   |  | 8. DATE OF BIRTH JUNE 12, 1882   |  |
| EX. F  |  | 6. COLOR OR RACE W   |  | 9. AGE (In years last birthday) 71   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED  |  | 10. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND                    |  |
| USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 14. MOTHER'S MAIDEN NAME ?   |  |
| FATHER'S NAME JOHN WITTIG  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS HARRY WILHELM 928 S. CLINTON ST.                           |  |
| WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |  | 18. CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 8. 570.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                     |  | (A) Cerebral Vascular Accident Secondary to operation for release of Intestinal Obstruction            |  | 8 days   |  |
| ANTECEDENT CAUSES  |  | (B)  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (C)  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |  |  |
| 9A. DATE OF OPERATION 7/21/53  |  | 19A. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7/16/53, 1953, to 7/18, 1953, that I last saw the deceased alive on 7/18, 1953, and that death occurred at 11:45 Am., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE William Doores M.D.   |  | 23B. ADDRESS Sinai Hospital, Balto. Md.  |  | 23C. DATE SIGNED July 18, 1953   |  |
| 24A. DATE July 21 1953   |  | 24B. NAME OF CEMETERY OR CREMATORY Western Cemetery  |  | 24C. LOCATION (City, town, or county) Edmondson Ave Balto Md                     |  |
| 24D. DATE RECEIVED BY REGISTRAR 11 21 1953   |  | 25. FUNERAL DIRECTOR John J. Duda Inc  |  | 25. ADDRESS 2829 Hudson St   |  |

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M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

53 6598

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6598  
Registered No.

BIRTH NO.

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BERNETTA</b>   |                                    | 2. DATE OF DEATH<br><b>July 20, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Provident Hospital</b>                                       |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| C. Length of stay in Baltimore<br><b>15 years</b>  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>1355 Woodyear Street</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>  | 8. DATE OF BIRTH<br><b>1879</b>              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b> |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>73</b> |
| 13. FATHER'S NAME  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Pa</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 16. SOCIAL SECURITY NO.  |                                    | 14. MOTHER'S MAIDEN NAME   |  |
| 17. INFORMANT<br><b>Ether Lewis</b>  |                                    | ADDRESS<br><b>1355 Woodyear St</b>   |  |

18. **422.1** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Arteriosclerotic Cardiovascular Disease**  
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

|   |  |   |  |   |
|---|--|---|--|---|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that I took charge of the remains described above, held an <b>inspection &amp; inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |

23A. SIGNATURE **R. B. Williams** 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **7-20-53**

|  |                             |  |  |
|--|-----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-23-53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>                     | 24D. LOCATION (City, town, or county) (State)<br><b>md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 21 1953</b>    |                             | 25. FUNERAL DIRECTOR<br><b>Huntington Williams, Mr. George S. Nelson</b> |  |
| REGISTRAR'S SIGNATURE                                      |                             | ADDRESS<br><b>1303 Brentman St</b>                                       |  |

OFFICE OF THE SECRETARY OF THE ARMY

MEMORANDUM

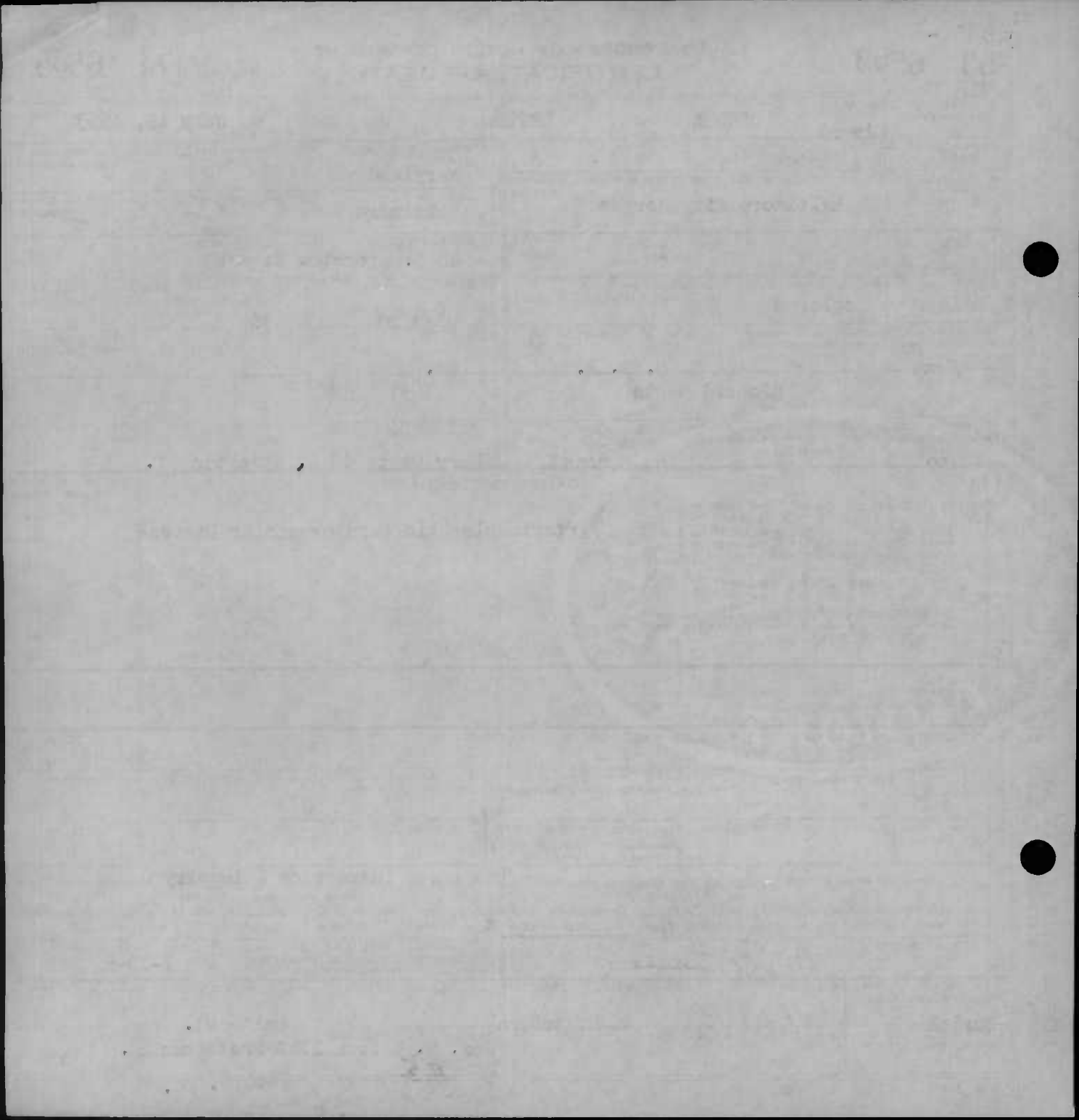
TO :

FROM :

SUBJECT :

RE :

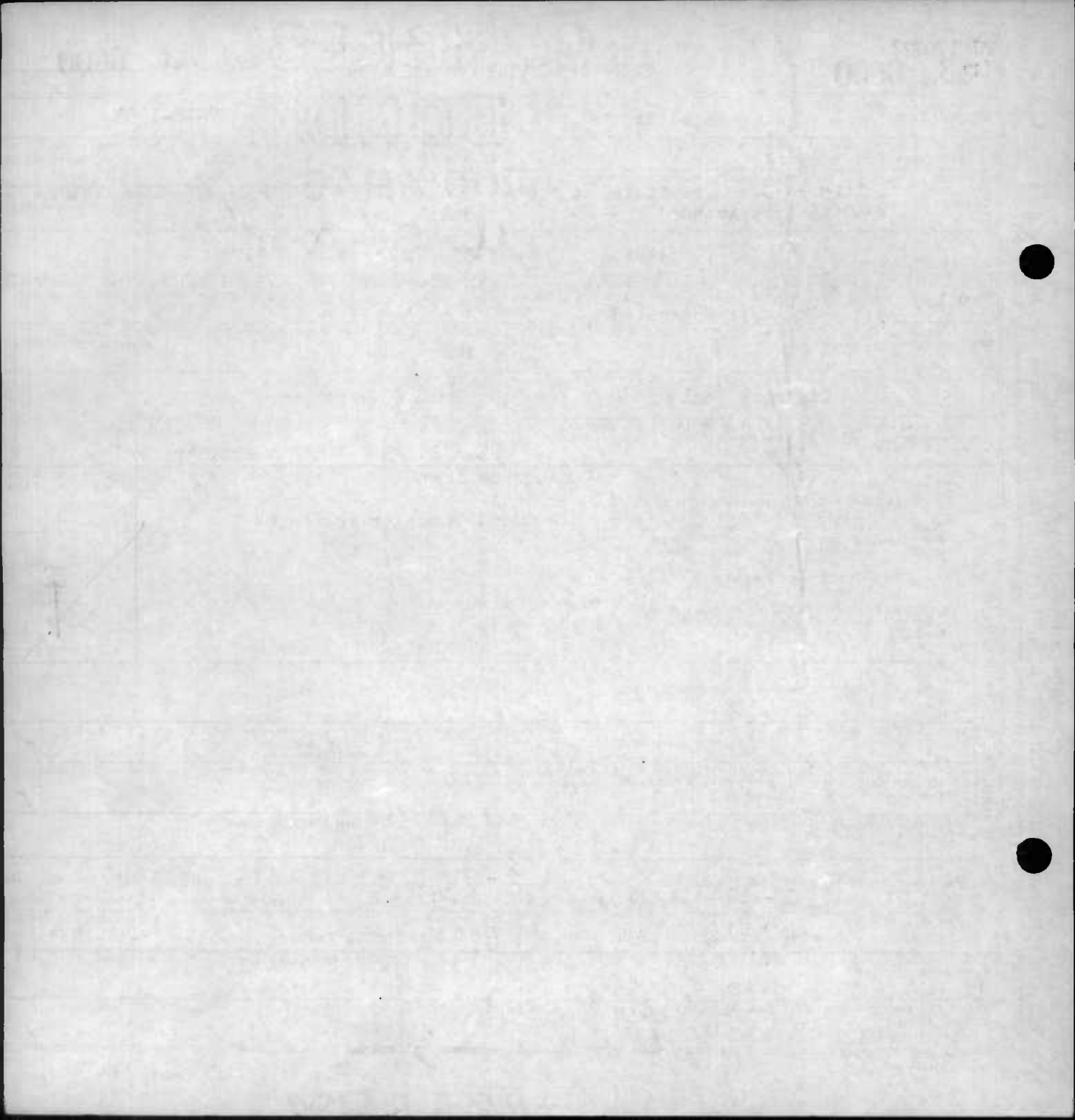




BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6600****B-620**  
**TJ 170772**  
**53 6600**  
BIRTH NO.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Hazel Brooks</b>  |                                  |   | 2. DATE OF DEATH<br><b>7-18-1953</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>                              |  |  |
| c. Length of stay in Baltimore <b>life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1359 N. Carey St. #17</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Separated</b> | 8. DATE OF BIRTH<br><b>May 27, 1907</b>  |  | 9. AGE (In years last birthday) <b>45</b><br>If Under 1 Year Months Days<br>If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>Clarence Neal</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ruth Stewart</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>B.C.H. 4940 Eastern Ave. (record)</b>  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. <b>331X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Accident?</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                    |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |  | 22. I hereby certify that I attended the deceased from <b>5 - 31 - 1953</b> , to <b>7 - 18 - 1953</b> that I last saw the deceased alive on <b>7 - 18, 1953</b> , and that death occurred at <b>4:25 P.m.</b> , from the causes and on the date stated above. |  |   |  |
| 23A. SIGNATURE<br><b>H. J. Jones</b><br>M. D.   |  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>  |  | 23C. DATE SIGNED<br><b>7-18-1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7-22-53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St Peters</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>md</b>  |  | 25. FUNERAL DIRECTOR<br><b>George G. Kelson</b>   |  | ADDRESS<br><b>1303 Preston St</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 21 1953</b><br>VS 150  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  |   |  |





-615

6601

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6601  
Registered No.

|  |                              |  |   |
|--|------------------------------|--|---|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><b>Robert H. Corbin</b>   |                              | 2. DATE OF DEATH<br><b>July 18, 1953</b>   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b><br>B. COUNTY <b>14-03</b>  |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>560 Laurens St</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto</b>   |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>14-03</b>   |                              | D. STREET ADDRESS (If rural, give location)<br><b>560 Laurens St</b>   |   |
| 7. SEX<br><b>M</b>   | 8. COLOR OR RACE<br><b>C</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>  | 10. DATE OF BIRTH<br><b>June 20, 1892</b> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>laborer</b>  |                              | 12. AGE (In years last birthday)<br><b>61</b>  |   |
| 13. FATHER'S NAME<br><b>Henry Corbin</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Anna Thompson</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>217-09-0143</b>  |   |
| 17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Myocardial infarction</b>                          |                              | 18. CAUSE OF DEATH<br>(A) <b>Myocardial infarction</b><br>(B) <b>Coronary atherosclerosis</b><br>(C) <b>Arteriosclerosis</b>   |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>None</b>  |                              | 20. INTERVAL BETWEEN ONSET AND DEATH<br><b>June 1953</b>   |   |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>None</b>   |                              | 22. I hereby certify that I attended the deceased from <b>June 18, 1953</b> to <b>July 18, 1953</b> , that I last saw the deceased alive on <b>July 18, 1953</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above. |   |
| 23. DATE OF OPERATION<br><b>0</b>  |                              | 24. MAJOR FINDINGS OF OPERATION<br><b>Myocardial infarction</b>  |   |
| 25. DATE OF OPERATION<br><b>0</b>  |                              | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                              | 28. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |   |
| 29. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>June 9, 1953</b>  |                              | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |
| 31. HOW DID INJURY OCCUR?<br><b>Heart attack</b>   |                              | 32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Home</b>   |   |
| 33. I hereby certify that I attended the deceased from <b>June 18, 1953</b> to <b>July 18, 1953</b> , that I last saw the deceased alive on <b>July 18, 1953</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above. |                              | 34. DATE SIGNED<br><b>7/20/53</b>  |   |
| 35. SIGNATURE<br><b>Robert H. Corbin</b>   |                              | 36. ADDRESS<br><b>145 E. Rose</b>  |   |
| 37. BURIAL, CREMATION, REMOVAL (Specify)<br><b>buried</b>  |                              | 38. DATE<br><b>7-22-53</b>   |   |
| 39. NAME OF CEMETERY OR CREMATORY<br><b>mt auburn</b>  |                              | 40. LOCATION (City, town, or county) (State)<br><b>md</b>  |   |
| 41. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |                              | 42. FUNERAL DIRECTOR<br><b>George S. Nelson</b>  |   |
| 43. ADDRESS<br><b>217 1/2 E. 1st St</b>  |                              | 44. ADDRESS<br><b>1303 Brewster St</b>   |   |

97099 1303 Brewster St

KANSAS CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Dr Phifer

1422 E. Chase St

1-420

3 6602

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6602  
Registered No.

1. NAME OF DECEASED (Last, first, middle, or Print) *Joseph Miles*

2. DATE OF DEATH *7-15-53.*

3. PLACE OF DEATH: *Baltimore City, Maryland*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE \_\_\_\_\_ B. COUNTY \_\_\_\_\_

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
*Provident Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Balto md 16-02*

6. Length of stay in Baltimore  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ Days \_\_\_\_\_

D. STREET ADDRESS (If rural, give location)  
*12164 Whitcoat St*

7. SEX *male* 8. COLOR OR RACE *Colored* 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *single*

10. DATE OF BIRTH *9/22/26* 11. AGE (In years last birthday) *27*

12. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  
*unemployed*

13. BIRTHPLACE (State or foreign country) *Virginia* 14. CITIZEN OF WHAT COUNTRY? *USA*

15. FATHER'S NAME *Wm. J. Miles*

16. MOTHER'S MAIDEN NAME *Esther Lassiter*

17. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)  
*no*

18. SOCIAL SECURITY NO. *None* 19. INFORMANT *Esther Miles* ADDRESS *1313 N. Bush St*

20. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
*Pulmonary Tuberculosis*

21. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(B) \_\_\_\_\_  
(C) \_\_\_\_\_

22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

23. INTERVAL BETWEEN ONSET AND DEATH

24. DATE OF OPERATION *7-20-53* 25. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 26. AUTOPSY? YES ☒ NO ☐

27. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 28. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

30. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 31. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 32. HOW DID INJURY OCCUR? \_\_\_\_\_

33. I hereby certify that I attended the deceased from *July 15*, 1953, to *July 15*, 1953, that I last saw the deceased alive on *July 15*, 1953, and that death occurred at *11:24* a. m., from the causes and on the date stated above.

34. SIGNATURE *Benigno R. Lopez* 35. ADDRESS *Provident Hospital* 36. DATE SIGNED *7-20-53*

37. BURIAL, CREMATION, REMOVAL (Specify) \_\_\_\_\_ 38. DATE \_\_\_\_\_ 39. NAME OF CEMETERY OR CREMATORY *Mt Auburn* 40. LOCATION (City, town, or county) *Balto. Md.* (State) \_\_\_\_\_

41. RECEIVED BY \_\_\_\_\_ 42. REGISTRAR'S SIGNATURE \_\_\_\_\_ 43. FUNERAL DIRECTOR *Geo. S. Nelson* ADDRESS *1303 Pussman St*

5/20/07

UNITED STATES OF AMERICA

1000



0-120

3 6603

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6603  
Registered No.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)   |  | 2. DATE OF DEATH  |  |
| Samuel DAVIS   |  | July 19, 1953   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  |  | A. STATE  |  |
| 900 N. Stricker St.  |  | Maryland  |  |
| 6. LENGTH OF stay in Baltimore   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)            |  |
| 20   |  | Baltimore 16-02   |  |
| 7. SEX   |  | D. STREET ADDRESS (If rural, give location)   |  |
| Male   |  | 900 N. Stricker St.   |  |
| 8. COLOR OR RACE   |  | E. DATE OF BIRTH  |  |
| Colored  |  | Feb. 28, 1893   |  |
| 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  | F. AGE (In years last birthday)   |  |
| MARRIED  |  | 60  |  |
| 10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  |  | G. BIRTHPLACE (State or foreign country)  |  |
| Laborer  |  | South Carolina  |  |
| 11. FATHER'S NAME  |  | H. CITIZEN OF WHAT COUNTRY?   |  |
| Samuel DAVIS   |  | U.S.A.  |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |  | 13. SOCIAL SECURITY NO.   |  |
| Yes World War I  |  | 217-01-9878   |  |
| 14. INFORMANT  |  | ADDRESS   |  |
| Irene Davis  |  | 900 N. Stricker St.   |  |
| 15. CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| (A) Cerebral Hemorrhage  |  | Day   |  |
| DUE TO   |  |   |  |
| (B) Carcinoma of Lung (left) Unknown   |  |   |  |
| DUE TO   |  |   |  |
| (C) Hypertensive Cardiovascular Disease Unknown  |  |   |  |
| 16. ANTECEDENT CAUSES  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |   |  |
| 17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |
| 18. DATE OF OPERATION  |  | 19. MAJOR FINDINGS OF OPERATION   |  |
| 0  |  |   |  |
| 20. AUTOPSY?   |  |   |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  |
| <input type="checkbox"/>   |  |   |  |
| 23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 24. HOW DID INJURY OCCUR?   |  |
|  |  |   |  |
| 25. I hereby certify that I attended the deceased from June 10, 1953, to July 19, 1953, that I last saw the deceased alive on July 19, 1953, and that death occurred at 8:30 P.M., from the causes and on the date stated above. |  |   |  |
| 26. SIGNATURE  |  | 27. ADDRESS   |  |
| Richard H. Hunt  |  | 1631 W. Franklin St.  |  |
| 28. DATE   |  | 29. DATE SIGNED   |  |
| 7-22-53  |  | 7-20-53   |  |
| 30. NAME OF CEMETERY OR CREMATORY  |  | 31. LOCATION (City, town, or county) (State)  |  |
| Tralto nat and   |  |   |  |
| 32. REGISTRAR'S SIGNATURE  |  | 33. FUNERAL DIRECTOR  |  |
| Huntington Williams  |  | George L. Nelson  |  |
| 34. ADDRESS  |  |   |  |
| 97099 1303 Presstman St  |  |   |  |

Wickham Wickham



530

6604

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6604

NAME OF DECEASED  
(Last, first, middle, or Print)

James H. Smith

2. DATE  
OF  
DEATH

July 18, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

622 Baker st

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

m

8. DATE OF BIRTH

Nov 15 1892

9. AGE (In years  
last birthday)

60

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

FATHER'S NAME

Amuel Smith

14. MOTHER'S MAIDEN NAME

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
217-07-2140

17. INFORMANT

ADDRESS

Sarah Smith, 622 Baker st

8. 144X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHI  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of mouth &amp; Throat

1-2 years

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Myocarditis, Inanition

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/18 1953, to 7/18 1953, that I last saw the  
deceased alive on 7/18 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Luther L. Boujones M. D.

23B. ADDRESS

722 N. Fulton Ave

23C. DATE SIGNED

7/20/53

BURIAL, CREMA-  
REMOVAL (Specify)

24B. DATE

7-21-53

24C. NAME OF CEMETERY OR CREMATORY

Arboretum

24D. LOCATION (City, town, or county) (State)

E RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

George S. Nelson

VS 150

97099 1303 Presstman st

Dr. Bandfield

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6605

BIRTH No. 53 6605

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>DAVID</b>   |                                    | 2. DATE OF DEATH<br><b>July 19, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF (not in hospital or institution, give street address or location)<br><b>Baltimore City Morgue</b> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| c. Length of stay in Baltimore<br><b>L</b>  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>617 N. Eden Street</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>  | 8. DATE OF BIRTH<br><b>1/10/10</b>                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chauffeur</b>   |                                    | 9. AGE (In years last birthday)<br><b>43</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b> |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>David Stafford</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Mary ?</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>                                     |                                    | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Marie Stafford 617 N. Eden St.</b>  |                                    | ADDRESS  |  |

|  |                                  |
|--|----------------------------------|
| 18. <b>002X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis</b><br>DUE TO<br>(A) <b>Pulmonary Tuberculosis</b><br>ANTECEDENT CAUSES<br>(B)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

MEDICAL CERTIFICATION

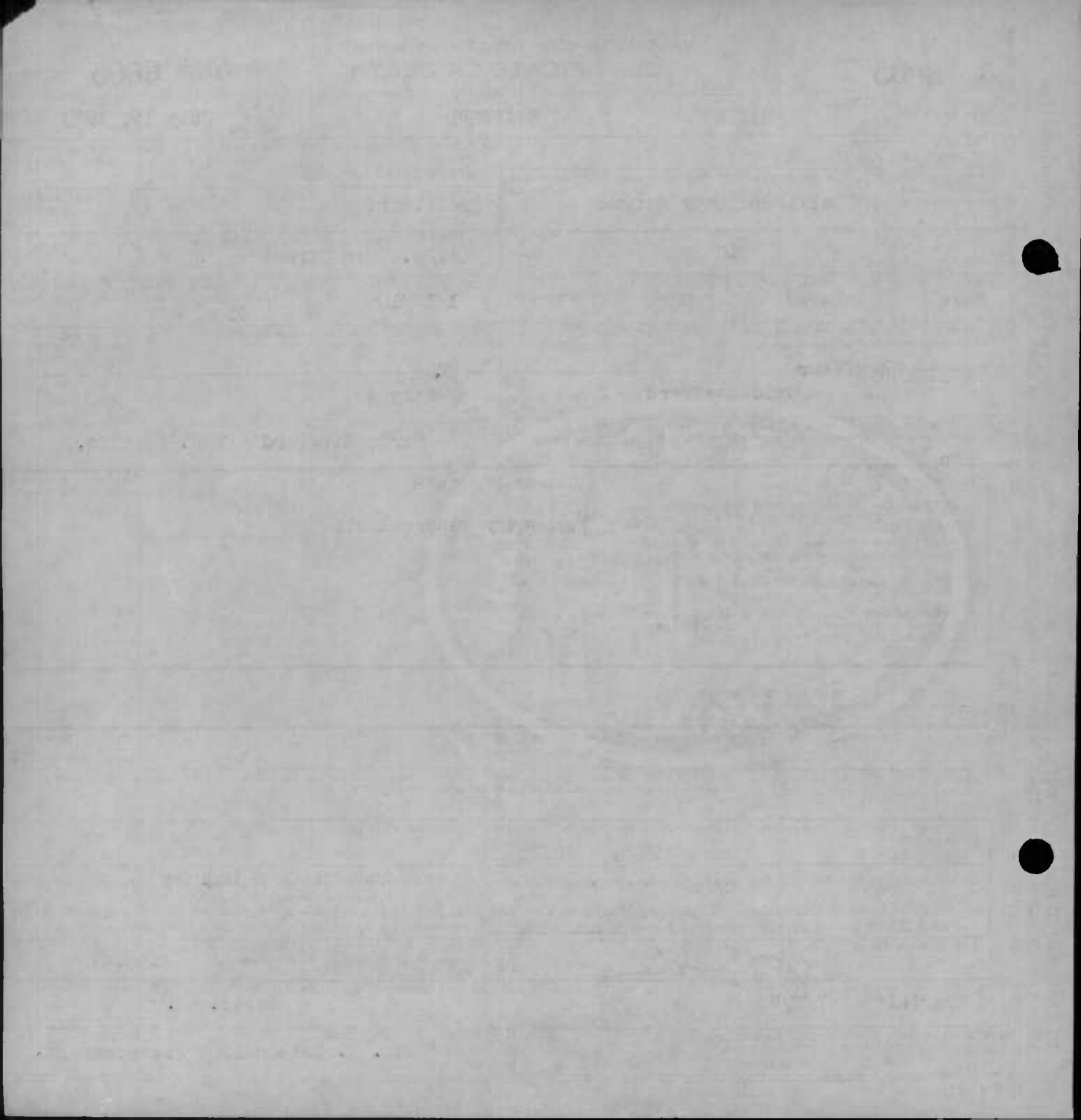
|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>inspection &amp; inquiry</b> thereon and from <b>Autopsy, Inspection or Inquiry</b> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><b>RAT Fisher</b>   |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>7-20-53</b>  |  |
| 24A. BURIAL CREMATION, REMAINS (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>7/23/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>mt Calvary</b>                             |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Geo. G. Kelson 1303 Presstman St.</b>   |  |   |  |

VS 151

68352 Geo. G. Kelson

ORIGINAL RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



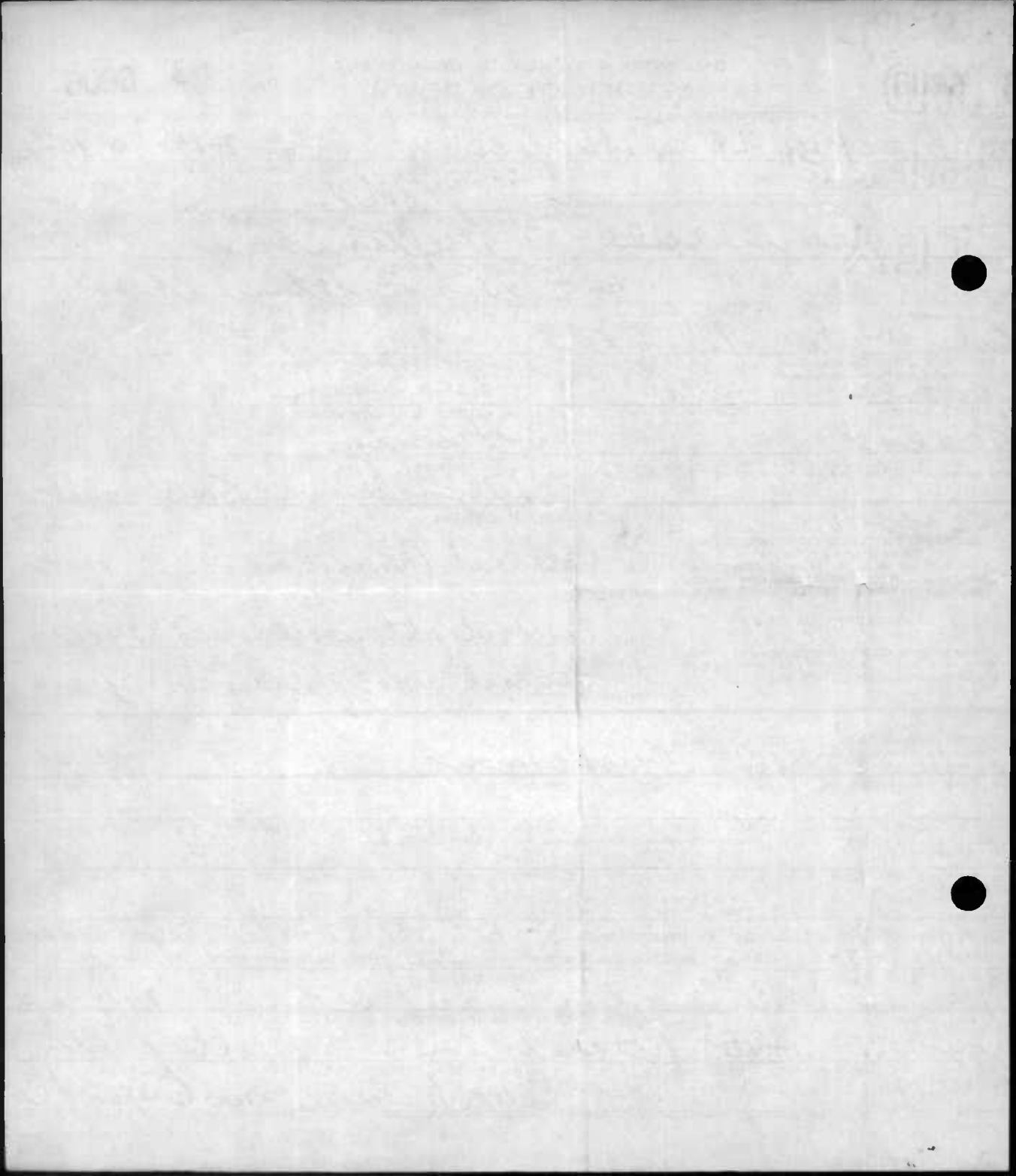
-624

6606

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6606

|   |  |  |  |
|---|--|--|--|
| NAME OF DECEASED<br>(Last, first, middle initial)<br><b>Miss LENA Margolis</b>  |  | 2. DATE OF DEATH<br><b>7-19-53 10<sup>10</sup> PM</b>  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>15-02</b> |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Leondale</b>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                   |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1510 Fulton Ave</b>   |  | E. AGE (In years last birthday) <b>73</b>  |  |
| F. SEX <b>Female</b> G. COLOR OR RACE <b>White</b> H. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>  |  | I. BIRTH PLACE (State or foreign country) <b>Russia</b>  |  |
| J. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>None</b>  |  | K. CITIZEN OF WHAT COUNTRY?  |  |
| L. FATHER'S NAME <b>Moses</b>   |  | M. MOTHER'S MAIDEN NAME <b>Huda</b>  |  |
| N. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |  | O. SOCIAL SECURITY NO.   |  |
| P. 332X   |  | Q. ADDRESS <b>Ralph Brown - 5614 Queensboro</b>  |  |
| R. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b>   |  | S. INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b>  |  |
| T. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Cerebral arteriosclerosis</b>   |  | U. <b>3 years</b>  |  |
| V. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Hypertension</b>   |  | W. <b>years</b>  |  |
| X. DATE OF OPERATION <b>0</b>   |  | Y. MAJOR FINDINGS OF OPERATION   |  |
| Z. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | AA. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| AB. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | AC. HOW DID INJURY OCCUR?  |  |
| AD. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)  |  | AE. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                           |  |
| AF. I hereby certify that I attended the deceased from <b>3-14</b> , 19 <b>51</b> , to <b>7-19</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-19</b> , 19 <b>53</b> , and that death occurred at <b>10<sup>10</sup> PM</b> , from the causes and on the date stated above. |  |  |  |
| AG. SIGNATURE <b>Jerome J. Blumberg</b> M.D.  |  | AH. ADDRESS <b>Leondale Home</b>   |  |
| AI. DATE SIGNED <b>7-19-53</b>  |  | AJ. DATE SIGNED <b>7-19-53</b>   |  |
| AK. DATE <b>7-21-53</b>   |  | AL. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>  |  |
| AM. LOCATION (City, town, or county) <b>Balto, Md</b>   |  | AN. ADDRESS <b>2100 Canton Pl</b>  |  |
| AO. RECEIVED BY <b>Huntington Williams</b>  |  | AP. REGISTRAR'S SIGNATURE <b>Wick Lewis</b>  |  |
| AQ. VS 150  |  | AR. FUNERAL DIRECTOR   |  |





-652

3 6607

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6607

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

PAULINE GHERNOCK

2. DATE  
OF  
DEATH

7-20-53

PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3926 Greenspring Ave Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md

15-12

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3926 Greenspring Ave

Length of stay in Baltimore

50 Yrs. Mos. Days

SEX 6. COLOR OR RACE

Female White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

52

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Isidore Glazer

14. MOTHER'S MAIDEN NAME

Mina

13. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Morris Chernock - Same

B. 153X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinomatosis  
DUE TO Carcinoma of sigmoid colon.

6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK ☐ WHILE AT ☐ WORK ☐

22. I hereby certify that I attended the deceased from Dec 1951, to July 20, 1953, that I last saw the  
deceased alive on July 20, 1953, and that death occurred at 11:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Isidore Glazer

23B. ADDRESS

3700 Park Heights Ave

23C. DATE SIGNED

7/21/53

BURIAL, CREMA-  
REMOVAL (Specify)

24B. DATE

7-21-53

24C. NAME OF CEMETERY OR CREMATORY

Isidore Glazer

24D. LOCATION (City, town, or county) (State)

Baltimore / Md

RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

Isidore Glazer

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Canton St

Kolman  
3700 Park Hgts  
li 9855

~~3700 Polyzint Road~~  
~~Ra 2029~~

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6608

H-616  
53 6608  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

David C. Harper

2. DATE  
OF  
DEATH

July 17, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

Ose 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 17-03

D. STREET ADDRESS (If rural, give location)

731 W. Franklin St.

c. Length of stay in Baltimore

18YRS.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-28-1900

9. AGE (In years  
last birthday)

53

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

WAITER

10B. KIND OF BUSINESS OR  
INDUSTRY

HOTEL

11. BIRTHPLACE (State or foreign country)

SPRINGFIELD, ILL.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DAVID C. HARPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL  
SECURITY NO.

217-03-8671

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 521X and 260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Empyema with Broncho-pneumal  
Fistula, RLL

ca. 4 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Putrid Lung Abscess, RLL

2 months

DUE TO

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/28, 1953, to 7/17, 1953, that I last saw the  
deceased alive on 7/17, 1953, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. P. A. Mc Intyre

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7-17-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/21/53

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN CEMETERY

24D. LOCATION (City, town, or county)

BALTO. MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

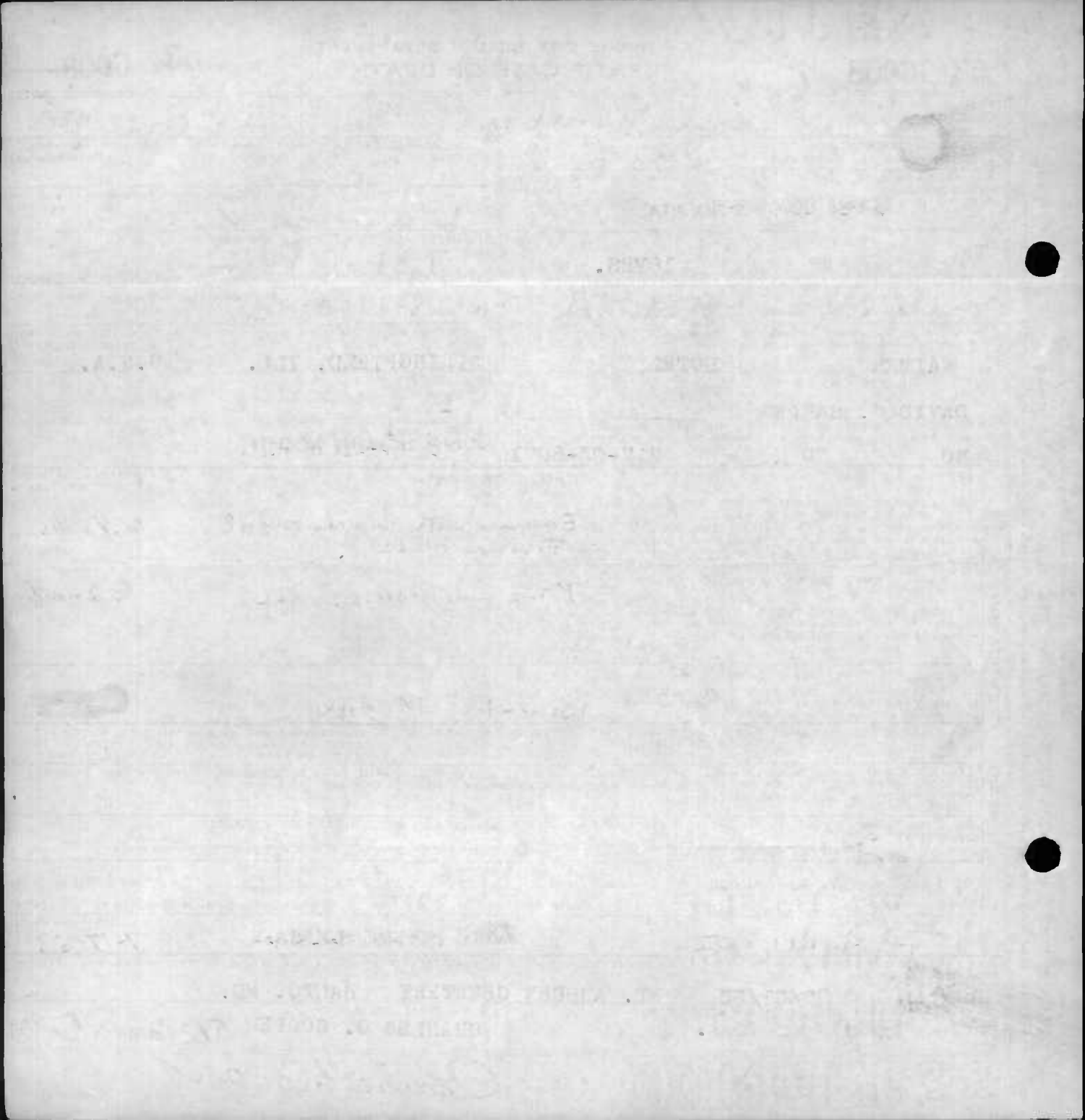
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

CHARLES G. COOPER

ADDRESS

512 Canoe Creek Ave



353

63 6609

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6609

TH NO.

NAME OF DECEASED  
(Last name or Print)

JOSEPH STINNETT

2. DATE  
OF  
DEATH

7/18/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

MERCY HOSP. INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

516 N. ARLINGTON ST

Length of stay in Baltimore

all life

SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9/10/890

9. AGE (In years,  
last birthday)

64

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

OUR BLENDER

10B. KIND OF BUSINESS OR  
INDUSTRY

BAKERY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

ROBT. STINNETT

14. MOTHER'S MAIDEN NAME

BETTY ST unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

NO

16. SOCIAL  
SECURITY NO.  
212106691

17. INFORMANT

SON

ADDRESS

ABOVE

18. 157X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) METASTATIC CARCINOMA, LIVER 3 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐HOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 1, 1953, to JULY 18, 1953, that I last saw the  
deceased alive on JULY 18, 1953, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

MERCY HOSPITAL

7/18/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

7/21/53

MT. AUBURN CEM.

BALTO. MD.

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams

CHAS. G. COOPER-512 CARROLLTON AV.

VS 150

690 44

Charles G. Cooper

02 000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

0000

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Age: [Illegible]

4. Date of Birth: [Illegible]

5. Date of Death: [Illegible]

6. Place of Birth: [Illegible]

7. Usual Residence: [Illegible]

8. Cause of Death: [Illegible]

9. Duration of Illness: [Illegible]

10. Name of Physician: [Illegible]

11. Name of Attending Nurse: [Illegible]

12. Name of Undertaker: [Illegible]

13. Name of Burial Place: [Illegible]

14. Name of Minister of Religion: [Illegible]

15. Name of Coroner: [Illegible]

16. Name of Registrar: [Illegible]

17. Name of Medical Examiner: [Illegible]

18. Name of Pathologist: [Illegible]

19. Name of Anatomist: [Illegible]

20. Name of Embalmer: [Illegible]

21. Name of Funeral Home: [Illegible]

22. Name of Cemetery: [Illegible]

23. Name of Grave: [Illegible]

24. Name of Interment: [Illegible]

25. Name of Burial: [Illegible]

26. Name of Cremation: [Illegible]

27. Name of Disposition: [Illegible]

28. Name of Final Resting Place: [Illegible]

29. Name of Final Disposition: [Illegible]

30. Name of Final Disposition: [Illegible]



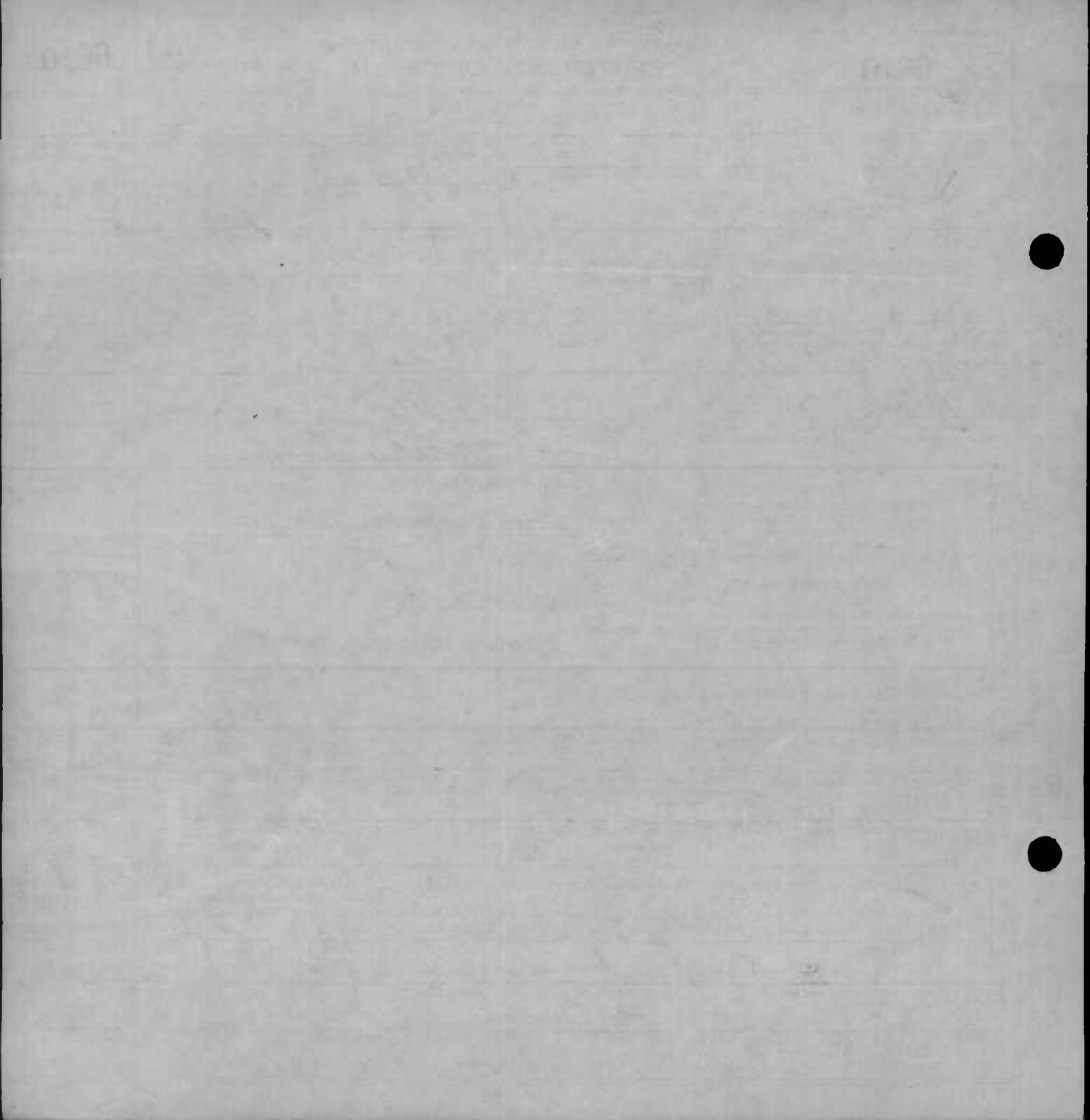
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6610**T-425  
53 6610  
BIRTH NO.

|   |                                 |   |   |   |  |
|---|---------------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM TILGHMAN</b>  |                                 |   | 2. DATE OF DEATH <b>July 17, 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                 |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>md</b> |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Morgue</b>  |                                 |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-02</b>         |   |  |
| C. Length of stay in Baltimore <b>unknown</b>   |                                 |   | D. STREET ADDRESS (If rural, give location) <b>1029 Madison St.</b>   |   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <b>Feb. 9 1906</b>   | 9. AGE (In years last birthday) <b>47</b> | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed Laborer</b> |                                 |   | 11. BIRTHPLACE (State or foreign country) <b>Piedmont Va.</b>   |   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                                 |   | 12. CITIZEN OF WHAT COUNTRY?  |   |  |
| 13. FATHER'S NAME <b>Littleton Miles</b>  |                                 |   | 14. MOTHER'S MAIDEN NAME <b>Martha Tilghman</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)              |                                 |   | 16. SOCIAL SECURITY NO.   |   |  |
| 17. INFORMANT <b>Martha Tilghman</b>  |                                 |   | ADDRESS <input checked="" type="checkbox"/>   |   |  |

|   |                                  |
|---|----------------------------------|
| 18. <b>491X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Bronchopneumonia, lower lobes</b><br><b>EXEMPT</b> | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>(B) <b>Pulmonary edema</b><br><b>EXEMPT</b>  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) <b>Coronary sclerosis, moderate</b>  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |

|   |   |   |
|---|---|---|
| 19A. DATE OF OPERATION  | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |
| 23A. SIGNATURE <b>R. J. [Signature]</b>   | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> | 23C. DATE SIGNED <b>July 17, 1953</b>   |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24B. DATE <b>July 21/53</b> | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>                          | 24D. LOCATION (City, town, or county) (State) <b>G. G. County Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR <b>Jul 21 1953</b>     |                             | 25. FUNERAL DIRECTOR <b>Mrs. R. H. G. [Signature]</b> ADDRESS <b>11297. Caroline St</b> |  |
| REGISTRAR'S SIGNATURE <b>Huntington Williams</b>        |                             |   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6611  
Registered No.

53 6611

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Amelia Jones

2. DATE  
OF  
DEATH

July 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

3601 B Parkview Avenue

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3601 B Parkview Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Jan. 6, 1906

9. AGE (In years,  
last birthday)

46

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Nebraska

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

---

14. MOTHER'S MAIDEN NAME

---

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Patricia B. Pompilo, 3601 B Parkview

18.

410X  
I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

(A)

DUE TO

Rheumatic Heart disease many years  
mitral stenosis; auricular

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

fibrillation; cardiac  
decompensation, acute  
with pleural effusion

(C)

2 mos

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19<sup>52</sup>, to 19<sup>53</sup>, that I last saw the  
deceased alive on 18 July 19<sup>53</sup>, and that death occurred at 4:45A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/21/53

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cemetery

24D. LOCATION (City, town, or county)

Woodlawn,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

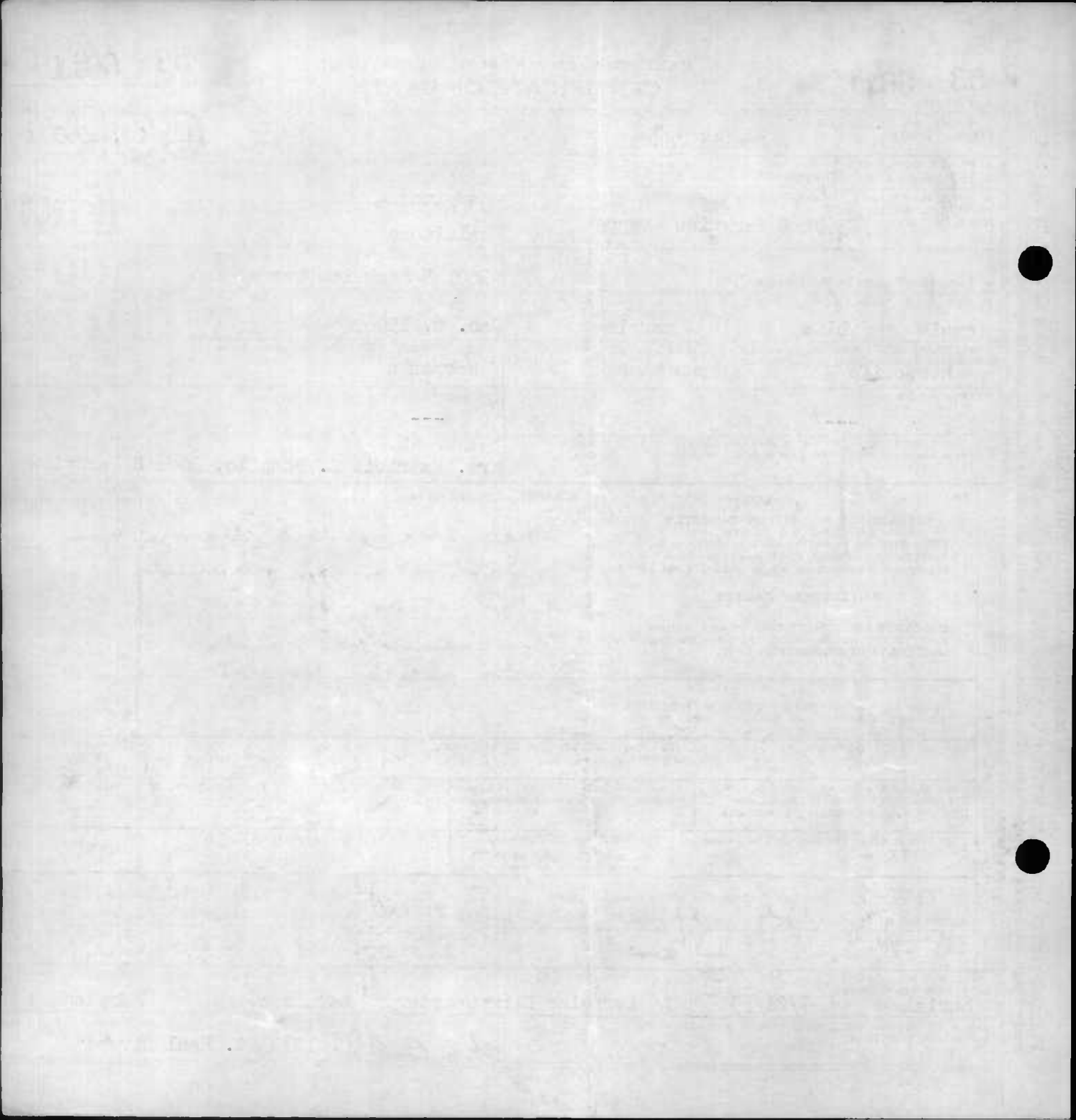
ADDRESS

JUL 21 1953

H. E. G. M.D.

25. FUNERAL DIRECTOR 1217 St. Paul Street

VS 150



252

53 6612

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6612

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Last, first, middle, or Print) <b>Susan Mary Washington</b>                                     |                                  | 2. DATE OF DEATH <b>7-20-53</b>  |  |
| 3. PLACE OF DEATH: <b>Baltimore City, Maryland Baltimore</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>25-32</b> |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>3317 Round Road</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>City (Baltimore)</b>                                  |  |
| 6. LENGTH OF STAY IN BALTIMORE <b>10 years</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>3317 Round Road</b>  |  |
| 7. SEX <b>male</b>  | 8. COLOR OR RACE <b>Negro</b>    | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   | 10. DATE OF BIRTH <b>Dec. 12, 1888</b>       |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) <b>Domestic</b>             | 12. KIND OF BUSINESS OR INDUSTRY | 13. AGE (In years last birthday) <b>65</b>   | 14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> |
| 15. FATHER'S NAME <b>Harry White</b>  |                                  | 16. MOTHER'S MAIDEN NAME <b>Mary Fleet</b>   |  |
| 17. HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>                           |                                  | 18. SOCIAL SECURITY NO. <b>none</b>  |  |
| 19. INFORMANT <b>Viola Caldwell</b>   |                                  | 20. ADDRESS <b>same</b>  |  |

|  |  |   |  |                                  |  |
|--|--|---|--|----------------------------------|--|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH                                  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) <b>Bacteremia</b>  |  | DUE TO  |  | <b>1 week.</b>                   |  |
| II. ANTECEDENT CAUSES  |  | (B) <b>Multiple Infectious Decubitus Ulcers</b> |  | <b>3 wks</b>                     |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | DUE TO  |  | <b>1 year</b>                    |  |
| (C) <b>Degenerative Myoatonia</b>  |  |   |  |                                  |  |

|  |  |                         |  |
|--|--|-------------------------|--|
| III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | <b>Chronic Debility</b> |  |
|--|--|-------------------------|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>July 20, 1953, 2:50 P. M.</b>               |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

2. I hereby certify that I attended the deceased from **Nov. 29, 1950**, to **July 20, 1953**, that I last saw the deceased alive on **July 20, 1953**, and that death occurred at **2:50 P. M.**, from the causes and on the date stated above.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3A. SIGNATURE <b>John P. Luck</b>                       |  | 23B. ADDRESS <b>427 Swale Ave</b>                    |  | 23C. DATE SIGNED <b>7-20-53</b>                      |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> |  | 24B. DATE <b>July 23</b>                             |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b> |  |
| 24D. LOCATION (City, town, or county) <b>Baltimore</b>  |  | 25. FUNERAL DIRECTOR <b>George H. Mayo</b>           |  | ADDRESS <b>609 George St</b>                         |  |
| 26. RECEIVED BY <b>21 1953</b>                          |  | 27. REGISTRAR'S SIGNATURE <b>Huntington Williams</b> |  | 28. VS 150   |  |

7208A

UNITED STATES DEPARTMENT OF HEALTH  
CENTROLOGICAL BUREAU

| PERSONAL HISTORY   |  | PHYSICAL EXAMINATION |  | LABORATORY EXAMINATIONS |  | TREATMENT            |  | REMARKS           |  |
|--------------------|--|----------------------|--|-------------------------|--|----------------------|--|-------------------|--|
| Name               |  | Age                  |  | Sex                     |  | Race                 |  | Date              |  |
| Address            |  | Occupation           |  | Marital Status          |  | Religion             |  | Referral          |  |
| Education          |  | Previous Illnesses   |  | Present Illness         |  | Family History       |  | Social History    |  |
| Allergies          |  | Vital Signs          |  | General Appearance      |  | Blood Tests          |  | X-ray             |  |
| Diet               |  | Heart                |  | Lungs                   |  | Urine                |  | Stool             |  |
| Exercise           |  | Liver                |  | Spleen                  |  | Spinal Fluid         |  | Other             |  |
| Sleep              |  | Kidneys              |  | Thyroid                 |  | Cultures             |  | Pathology         |  |
| Mental Status      |  | Gastrointestinal     |  | Endocrine               |  | Microbiology         |  | Immunology        |  |
| Mental History     |  | Genitourinary        |  | Neurological            |  | Histology            |  | Cytology          |  |
| Mental Examination |  | Reproductive         |  | Psychiatric             |  | Immunohistochemistry |  | Molecular Biology |  |
| Mental Treatment   |  | Other                |  | Other                   |  | Other                |  | Other             |  |



200

3 6613

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6613

NAME OF DECEASED  
(Last, first, middle or Print)

ANNA R. NOWAK

2. DATE  
OF  
DEATH

July 20, 1953

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
737 E. 35<sup>th</sup> St.4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE MARYLAND B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE 9-02Length of stay in Baltimore 47 Yrs. ~~Now~~ ~~Days~~D. STREET ADDRESS (If rural, give location)  
1737 E. 35<sup>th</sup> St.6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
WIDOWED

8. DATE OF BIRTH July 15, 1886 9. AGE (In years, last birthday) 67

10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  
none

11. BIRTHPLACE (State or foreign country) POLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Vincent Rulski

14. MOTHER'S MAIDEN NAME Regina (Rulska) -?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO. 17. INFORMANT Sigmund R. Nowak ADDRESS 408 S. Patt. Ch. Ave.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary Thrombosis Sudden  
DUE TO  
(B) Atherosclerotic Heart Disease  
DUE TO  
(C)

3 yrs -

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from Jan. 1952, to July 1952, 19, that I last saw the deceased alive on 19, and that death occurred at m., from the causes and on the date stated above.

3a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

3b. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

3c. RECEIVED BY REGISTERAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS

3d. AL REGISTRAR

3e. VS 150

11 E. Chase St  
Huntington Williams, Fred W. Ozogowski  
1930 Eastern Ave

1943

CERTIFICATE OF DEATH

1943

Anna E. Brown

1943

1943

1943

1943

1943

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263

-436

6615

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6615

TH NO.

NAME OF DECEASED  
(or Print)

MILTON WALDORF

2. DATE  
OF  
DEATH

7-19-53

PLACE OF DEATH:

Baltimore City, Maryland Baltimore, Md.

FULL NAME OF (If not in hospital or institution, give street address or location)

Riviera Apt. Linden Ave &amp; Lake Drive

HOSPITAL OR  
INSTITUTION

eng of stay in Baltimore life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Maryland 13-01

D. STREET ADDRESS (If rural, give location)

Linden Ave. &amp; Lake Drive

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

June 17, 1887

9. AGE (in years  
last birthday)

66

If Under 1 Year  
Months: Days

1 2

If Under 24 Hours  
Hours Min.USUAL OCCUPATION (Give kind of  
life during most of working life, even if retired)

merchant

10B. KIND OF BUSINESS OR  
INDUSTRY

men's clothing

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

FATHER'S NAME

Henry Waldorf

14. MOTHER'S MAIDEN NAME

Hass

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

O

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bessie H. Waldorf, Riviera Apt-1D

I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

1 Month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Diabetes

MANY YEARS

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from 6-22, 1953, to 7-19, 1953, that I last saw the  
deceased alive on 7-19, 1953, and that death occurred at 2:45 Pm., from the causes and on the date stated above.

3A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Norman L. Miller

M. D.

Scripps Hosp of Balto. Inc.

7-19-53

BURIAL, CREMA-  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-21-53

Hebrew Friendship Cem.

Baltimore, Maryland

RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

21-1953

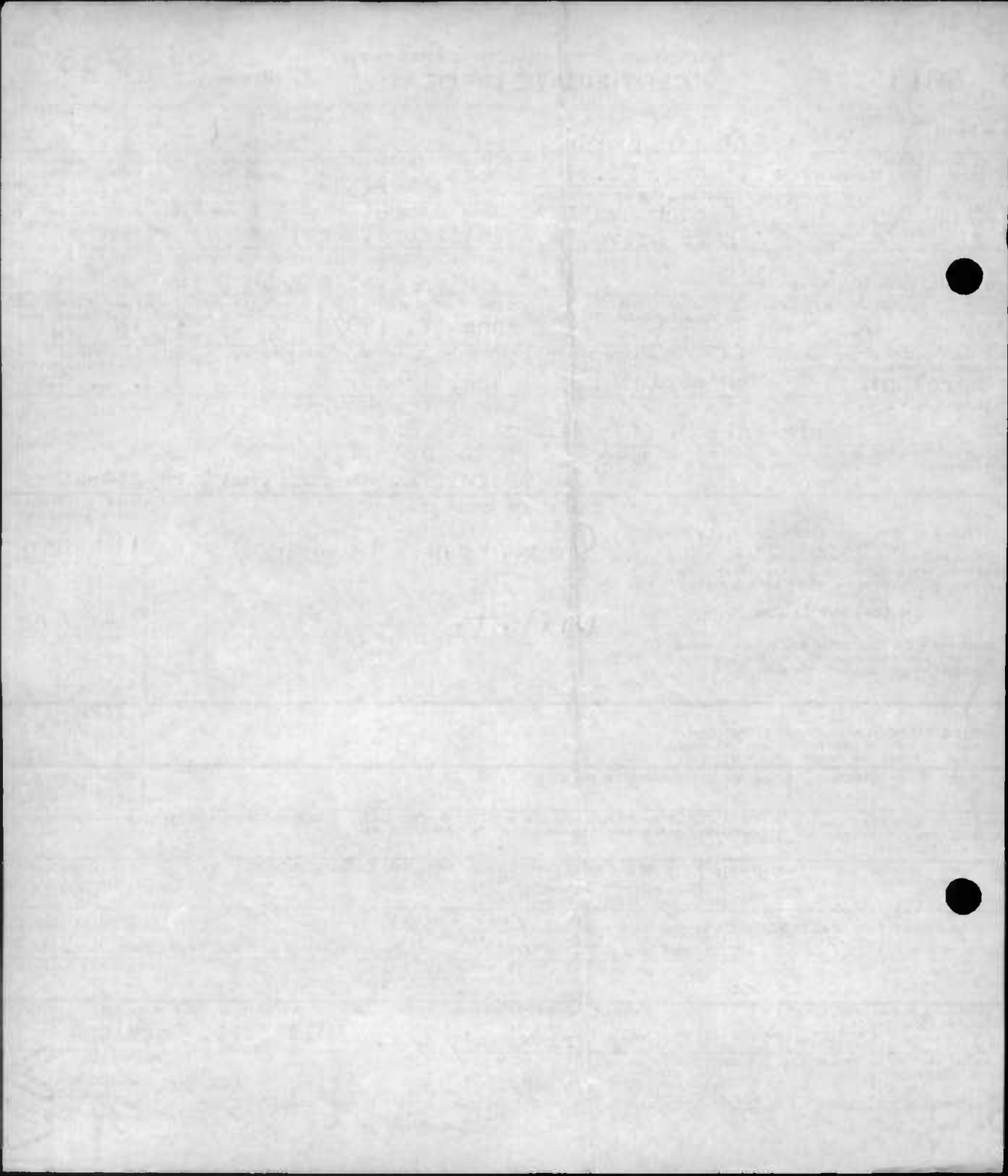
Huntington Williams

David R. Martin, 1902 Eutaw Place

VS 150

2906 E

David R. Martin





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6816  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Margaret A. Stone

2. DATE  
OF  
DEATH

July 18, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

11-03

D. STREET ADDRESS (If rural, give location)

834 Park Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Jan. 23, 1889

9. AGE (In years  
last birthday)

64

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Michael F. Manning

14. MOTHER'S MAIDEN NAME

Mary Loftus

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. J. Dan Stone 834 Park Avenue

18. 197X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myxo-sarcoma left thigh

5 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Sarcoma  
Broncho-Pneumonia

36 hrs.

CUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

6/23-53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Sarcoma

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1953, to July 18, 1953, that I last saw the  
deceased alive on July 18, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

E. S. Shawman

M. D.

23B. ADDRESS

13 E Eager St, Balto

23C. DATE SIGNED

7-21-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 22, 1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Leonard J. Ruck

ADDRESS

5305 Harford Road.

Eugene Hayward  
ast Eager Street

53 6617

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6617

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. George F. Kreis

2. DATE  
OF  
DEATH

July 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

3318 Westerwald Avenue

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

3318 Westerwald Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Apr. 12, 1878

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired Lowes

10B. KIND OF BUSINESS OR  
INDUSTRY

Motion Pictures

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Francis P. Kreis

14. MOTHER'S MAIDEN NAME

Anna Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Howard F. Kreis, 3318 Westerwald

18. 331X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerosis  
generalized

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/17/53, 19, to 7/20, 1953 that I last saw the  
deceased alive on 7/20, 1953 and that death occurred at 10<sup>10</sup> A.M., from the causes and on the date stated above.

23A. SIGNATURE

Louis F. Klines

M. D.

23B. ADDRESS

2623 E. Neumann St.

23C. DATE SIGNED

7/20/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 22, 1953

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

FUNERAL DIRECTOR

Leonard J. Ruck, 5305 Harford Road.



600  
3 6618

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6618  
Registered No.

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)<br><b>Pahr, Daisy Margaret</b>  |                               | 2. DATE OF DEATH<br><b>July 20, 1953</b>  |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>St. Joseph's</b>   |                               | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |
| 7. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days<br><b>27-07</b>   |                               | 8. D. STREET ADDRESS (If rural, give location)<br><b>2919 Harview Avenue</b>  |  |
| 9. SEX<br><b>W.</b>  | 6. COLOR OR RACE<br><b>W.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>July 3 - 1886</b>     |
| 10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>Wife.</b>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 9. AGE (In years last birthday)<br><b>67</b> |
| 11. FATHER'S NAME<br><b>John Lacher</b>  |                               | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore - Md</b>  |  |
| 12. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. SOCIAL SECURITY NO.<br><b>150X</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>EMMA Schott</b>  |  |
| 15. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of esophagus</b><br>with<br><b>Metastasis to trachea</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Antecedent causes</b> |                               | 16. ADDRESS<br><b>MR. FRANK C. PAHR-SR - SAME</b>   |  |
| 17. DATE OF OPERATION<br><b>July 20, 1953</b>  |                               | 18. MAJOR FINDINGS OF OPERATION<br><b>Carcinoma of esophagus with metastasis to trachea</b>   |  |
| 19. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21. TIME (Month) (Day) (Year) (Hour) (Minute)<br><b>July 20, 1953</b>  |                               | 22. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>10:32a.m.</b>                                    |  |
| 23. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 24. HOW DID INJURY OCCUR?<br><b>10:32a.m.</b>   |  |
| 25. I hereby certify that I attended the deceased from <b>June 30, 1953</b> , to <b>July 20, 1953</b> that I last saw the deceased alive on <b>July 20, 1953</b> , and that death occurred at <b>10:32a.m.</b> , from the causes and on the date stated above.   |                               |   |  |
| 26. SIGNATURE<br><b>B. B. Velox</b>  |                               | 27. ADDRESS<br><b>1100 N. Caroline Street</b>   |  |
| 28. DATE<br><b>7-23-1953</b>   |                               | 29. DATE SIGNED<br><b>July 20, 1953</b>   |  |
| 30. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 31. NAME OF CEMETERY OR CREMATORY<br><b>Louison Park Cem.</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |                               | 33. LOCATION (City, town, or county) (State)<br><b>BALTO Md</b>   |  |
| 34. RECEIVED BY<br><b>21</b>   |                               | 35. FUNERAL DIRECTOR<br><b>Leonard J. Ruck</b>  |  |
| 36. ADDRESS<br><b>5305 Harford</b>   |                               |   |  |





636  
6819

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6619

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>(Last, first, middle, or Print)  |  | 2. DATE OF DEATH   |  |
| James Treat Carter   |  | 7-18-53  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)   |  | A. STATE   |  |
| Union Memorial Hospital  |  | MD.  |  |
| CITY OR TOWN   |  | B. COUNTY  |  |
| Baltimore  |  | Baltimore City   |  |
| STREET ADDRESS (If rural, give location)   |  | CITY OR TOWN   |  |
| 212 Longwood Road  |  | 27-13  |  |
| D. DATE OF BIRTH   |  | 9. AGE (in years last birthday)  |  |
| August 4 1891  |  | 61   |  |
| 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Wisconsin  |  | USA  |  |
| 14. MOTHER'S MAIDEN NAME   |  | 17. INFORMANT  |  |
| Jeannie McClelland   |  | Mrs. Irene M. Carter (wife)  |  |
| 16. SOCIAL SECURITY NO.  |  | ADDRESS  |  |
| 25-18-2111   |  | Longwood Rd.   |  |
| CAUSE OF DEATH   |  |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  |  |  |
| (A) Acute G.I. Hemorrhage  |  |  |  |
| DUE TO   |  |  |  |
| (B) Duodenal Ulcer   |  |  |  |
| DUE TO   |  |  |  |
| (C)  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                          |  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 9A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 7-12-53  |  | Large duodenal ulcer which included Ampulla  |  |
| 1A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21E. INJURY OCCURRED   |  |
| 1D. TIME (Month) (Day) (Year) (Hour) (Minute)  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |  |
| 21F. HOW DID INJURY OCCUR?   |  | 23B. ADDRESS   |  |
| 23C. DATE SIGNED   |  | 23D. LOCATION (City, town, or county) (State)  |  |
| 23E. SIGNATURE   |  | 23F. SIGNATURE   |  |
| Louise Schaeffer   |  | Union Memorial Hospital  |  |
| 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY   |  |
| July 21/53   |  | Greenmount Cemu.   |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 25. FUNERAL DIRECTOR   |  |
| Baltimore, Maryland  |  | Stewart & Mowen Co., 108 W. North Ave.   |  |
| 25. RECEIVED BY AL REGISTRAR   |  | 26. ADDRESS  |  |
| Huntington Williams, M.D.  |  | City #1.   |  |
| VS 150   |  |  |  |
| 29071  |  |  |  |

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6620  
Registered No. 53 6620N-655  
53 6620  
BIRTH NO.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Anna Miller Thorman</i>   |                                  | 2. DATE OF DEATH<br><i>July-20-1953</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Upler 3</i>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD</i><br>B. COUNTY <i>67-04</i> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>33</i> <b>JOHNS HOPKINS HOSPITAL</b>                                    |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Baltimore</i> <b>Baltimore</b>                    |   |
| D. LENGTH OF STAY IN BALTIMORE<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>3530 Helton Rd</i> <b>1925 Guilford Ave</b>   |   |
| 5. SEX<br><i>female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>   | 8. DATE OF BIRTH<br><i>May 8, 1869</i> <b>May 8, 1869</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Teacher</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>NOT KNOWN</b>  |   |
| 13. FATHER'S NAME<br><b>NOT KNOWN</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>NOT KNOWN</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>217-26-3951-A</b>   |   |
| 17. INFORMANT<br><b>JOHNS HOPKINS HOSPITAL</b>  |                                  | ADDRESS   |   |

|   |                                  |
|---|----------------------------------|
| 18. <i>331X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <i>Cerebral vascular accident</i><br>DUE TO<br>(B) <i>Generalized arteriosclerosis</i><br>DUE TO<br>(C) <i>Bronchopneumonia</i> | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><i>7-20-1953</i>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from *7-20-1953* to *7-20-1953*, that I last saw the deceased alive on *7-20-1953*, and that death occurred at *12* m., from the causes and on the date stated above.23A. SIGNATURE *Henry H. Wagner Jr.* 23B. ADDRESS **JOHNS HOPKINS HOSPITAL** 23C. DATE SIGNED *7/20/53*

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><i>July 22, 1953</i> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loddon Park Cemetery</b>             | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore - Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>Jul 21 1953</i>     |                                   | 25. FUNERAL DIRECTOR<br><b>Stewart &amp; Mowen Company - 108 W North Ave.</b> |   |
| REGISTRAR'S SIGNATURE<br><i>Huntington Williams Jr.</i>    |                                   | ADDRESS   |   |

Balto - 1

**CERTIFICATE OF DEATH**  
**BALTIMORE CITY HEALTH DEPARTMENT**

Revised 1-2-60

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| NAME OF DECEASED<br>[Faint handwritten text]     |  | SEX<br>[Faint handwritten text]                    |  | AGE<br>[Faint handwritten text]                          |  | DATE OF BIRTH<br>[Faint handwritten text]                       |  |
| PLACE OF BIRTH<br>[Faint handwritten text]       |  | OCCUPATION<br>[Faint handwritten text]             |  | MARITAL STATUS<br>[Faint handwritten text]               |  | DATE OF DEATH<br>[Faint handwritten text]                       |  |
| PLACE OF DEATH<br>[Faint handwritten text]       |  | CAUSE OF DEATH<br>[Faint handwritten text]         |  | MANNER OF DEATH<br>[Faint handwritten text]              |  | SIGNATURE OF DECEASED<br>[Faint handwritten text]               |  |
| SIGNATURE OF WITNESS<br>[Faint handwritten text] |  | SIGNATURE OF PHYSICIAN<br>[Faint handwritten text] |  | SIGNATURE OF CORONER<br>[Faint handwritten text]         |  | SIGNATURE OF JUDGE<br>[Faint handwritten text]                  |  |
| SIGNATURE OF CLERK<br>[Faint handwritten text]   |  | SIGNATURE OF REGISTRAR<br>[Faint handwritten text] |  | SIGNATURE OF CHIEF OF BUREAU<br>[Faint handwritten text] |  | SIGNATURE OF DEPUTY CHIEF OF BUREAU<br>[Faint handwritten text] |  |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

# LEWIS

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 53 6621

 53 6621 168420  
 BIRTH NO.

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William L ewis</b>  |                                  |  | 2. DATE OF DEATH<br><b>7-18-53</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospital<br/>4940 Eastern Ave.</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                          |  |   |
| c. Length of stay in Baltimore <b>50 yrs.</b>   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>530 N. Vincent St.-17</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid.</b> | 8. DATE OF BIRTH<br><b>April 6, 1880</b>  |  | 9. AGE (In years last birthday)<br><b>73</b>                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Reporter</b>  |                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>               |
| 13. FATHER'S NAME<br><b>Jerry Lewis</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Hill</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | (If yes, give war or dates of service)                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>B. C. H. Records, 4940 Eastern Ave.</b> |

18. **493x** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Encephalo - Mylitis**

DUE TO

ANTECEDENT CAUSES

(B) **Pneumonia right lung**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

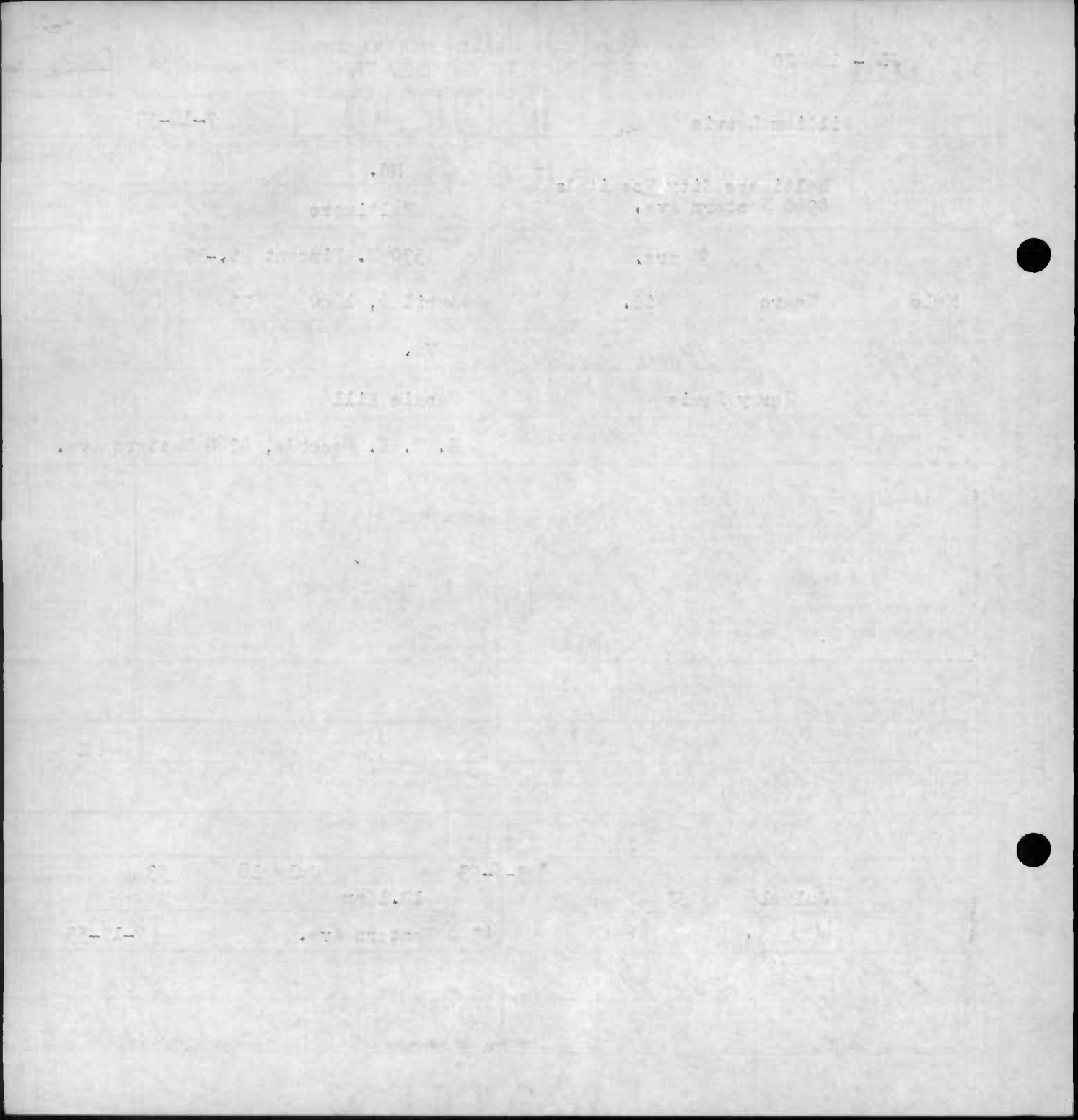
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>7</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |

22. I hereby certify that I attended the deceased from **3-6-53**, 19**53**, to **July 18**, 19**53**, that I last saw the deceased alive on **July 18**, 19**53**, and that death occurred at **12.15pm** from the causes and on the date stated above.

23A. SIGNATURE **H. J. Johnson** M. O. 23B. ADDRESS **4940 Eastern Ave.** 23C. DATE SIGNED **7-19-53**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>7/22/1953</b>                      |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>W. H. Culburn Cem. Balto.</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR                           |  | REGISTRAR'S SIGNATURE<br><b>Antington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>Mr. J. B. Williams - N. School St.</b>      |  | ADDRESS   |  |





## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 6622BIRTH NO. 53 6622 +9-220441. NAME OF DECEASED  
(Type or Print)WOODROW WALKER2. DATE  
OF  
DEATHJuly 18, 19533. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTESt. Joseph HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto.D. STREET ADDRESS (If rural, give location)  
448 E. Federal St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 4, 1949

9. AGE (In years last birthday)

3

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Melvin Smith

14. MOTHER'S MAIDEN NAME

Bertha Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Bertha Walker 448 E. Federal St.18. 344.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

HYDROCEPHALUS, MARKED

DUE TO

## ANTECEDENT CAUSES

(B)

EMACIATION, MARKED

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an PARTIAL AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR

23C. DATE SIGNED

7-19-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7/21/1953

24C. NAME OF CEMETERY OR CREMATORY

W. T. Calver Cem. Balto.

24D. LOCATION (City, town, or county)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

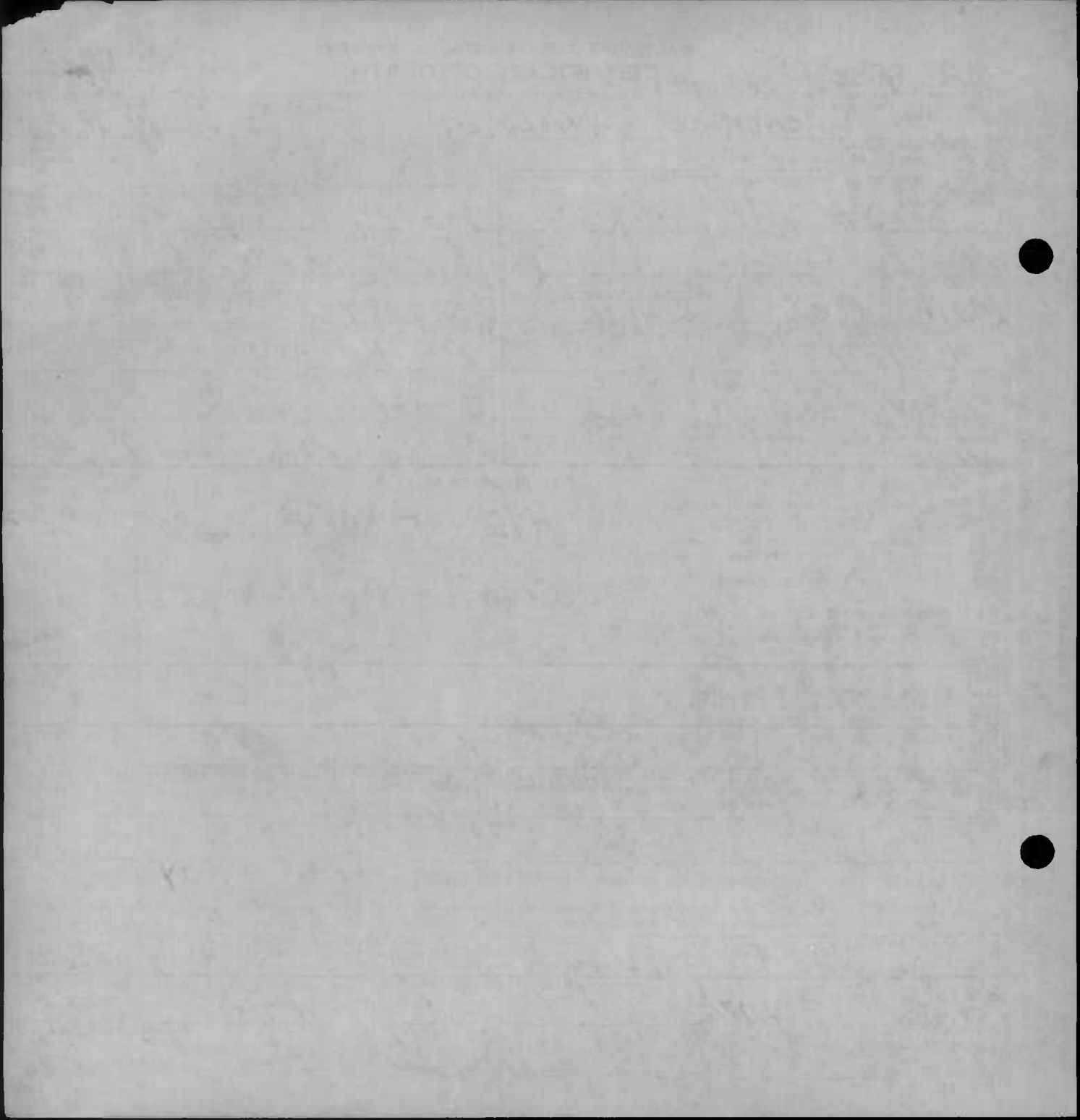
Wilmington Williams

25. FUNERAL DIRECTOR

W. T. Williams

ADDRESS

8529



| Baltimore City Health Department  |                        |  |  | 53 6623  |  |
|---|------------------------|--|--|--|--|
| Certificate of Death  |                        |  |  | Registered No.   |  |
| BIRTH NO. 53 6623   |                        |  |  | DATE OF DEATH July 20, 1953  |  |
| 1. NAME OF DECEASED (Type or Print) IDA PEARL   |                        |  |  | 7-2-53   |  |
| 2. PLACE OF DEATH: A. Baltimore City, Maryland Acc Room   |                        |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL   |                        |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-02                  |  |
| c. Length of stay in Baltimore Yrs. Mos. Days   |                        |  |  | D. STREET ADDRESS (If rural, give location) 237 S. Regester St   |  |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow  | 8. DATE OF BIRTH JAN. 12, 1                          | 9. AGE (In years last birthday) 64   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE   |                        |  | 11. BIRTHPLACE (State or foreign country) SAVAGE, MD | 12. CITIZEN OF WHAT COUNTRY? USA   |  |
| 13. FATHER'S NAME BENJAMIN Phelps   |                        |  | 14. MOTHER'S MAIDEN NAME LAVINA SMITH                |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No   |                        |  | 16. SOCIAL SECURITY NO.                              |  |  |
| 17. INFORMANT ADDRESS   |                        |  | JOHNS HOPKINS HOSPITAL                               |  |  |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                |                        |  |  | CAUSE OF DEATH   |  |
| ANTECEDENT CAUSES   |                        |  |  | (A) HYPERTENSIVE AND ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                        |  |  | (B) DISEASE  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                        |  |  | (C)  |  |
| 19A. DATE OF OPERATION 0  |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                       |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                     |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                        | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7/20, 1953 to 7/20, 1953, that I last saw the deceased alive on 7/20, 1953 and that death occurred at 4:15 p.m., from the causes and on the date stated above. |                        |  |  |  |  |
| 23A. SIGNATURE A. H. Owens, Jr. M. D.   |                        |  | 23B. ADDRESS JOHNS HOPKINS HOSPITAL                  |  | 23C. DATE SIGNED 7-20-53   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  | 24B. DATE 7-23-53      | 24C. NAME OF CEMETERY OR CREMATORY MORELAND MEM. BALTO.  |  | 24D. LOCATION (City, town, or county) (State) Md   |  |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE  | 25. FUNERAL DIRECTOR   |  | ADDRESS  |  |
|   |                        | Thos. J. Blight  |  | 6009 Harford Rd  |  |

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1903.  
REPORT OF THE  
COMMISSIONERS OF THE  
DEPARTMENT OF  
CORRECTIONS.

RECEIVED  
JAN 1 1903  
DEPT. OF CORRECTIONS  
ALBANY, N. Y.

4-322 CERTIFICATE CORRECTED

7-23-53

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 6624

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT E. LEE HODGES

2. DATE OF DEATH  
July 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5520 Liberty Heights

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 2, 1898

9. AGE (In years last birthday)

54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auto Dealer

10B. KIND OF BUSINESS OR INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles S. Hodges

14. MOTHER'S MAIDEN NAME

Gertrude V. Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
216-20-216717. INFORMANT ADDRESS  
Mr. R. E. L. Hodges, Jr. - 5522 Liberty / Hgts. Ave

18. E976X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of right temple

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

5520 Liberty Heights

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

7-19-53 4:40 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

J. R. O. [Signature]

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
7-20-5324A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

7/22/53

24C. NAME OF CEMETERY OR CREMATORY

M.P. Church Cem.

24D. LOCATION (City, town, or county)

Finksburg, Carroll Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

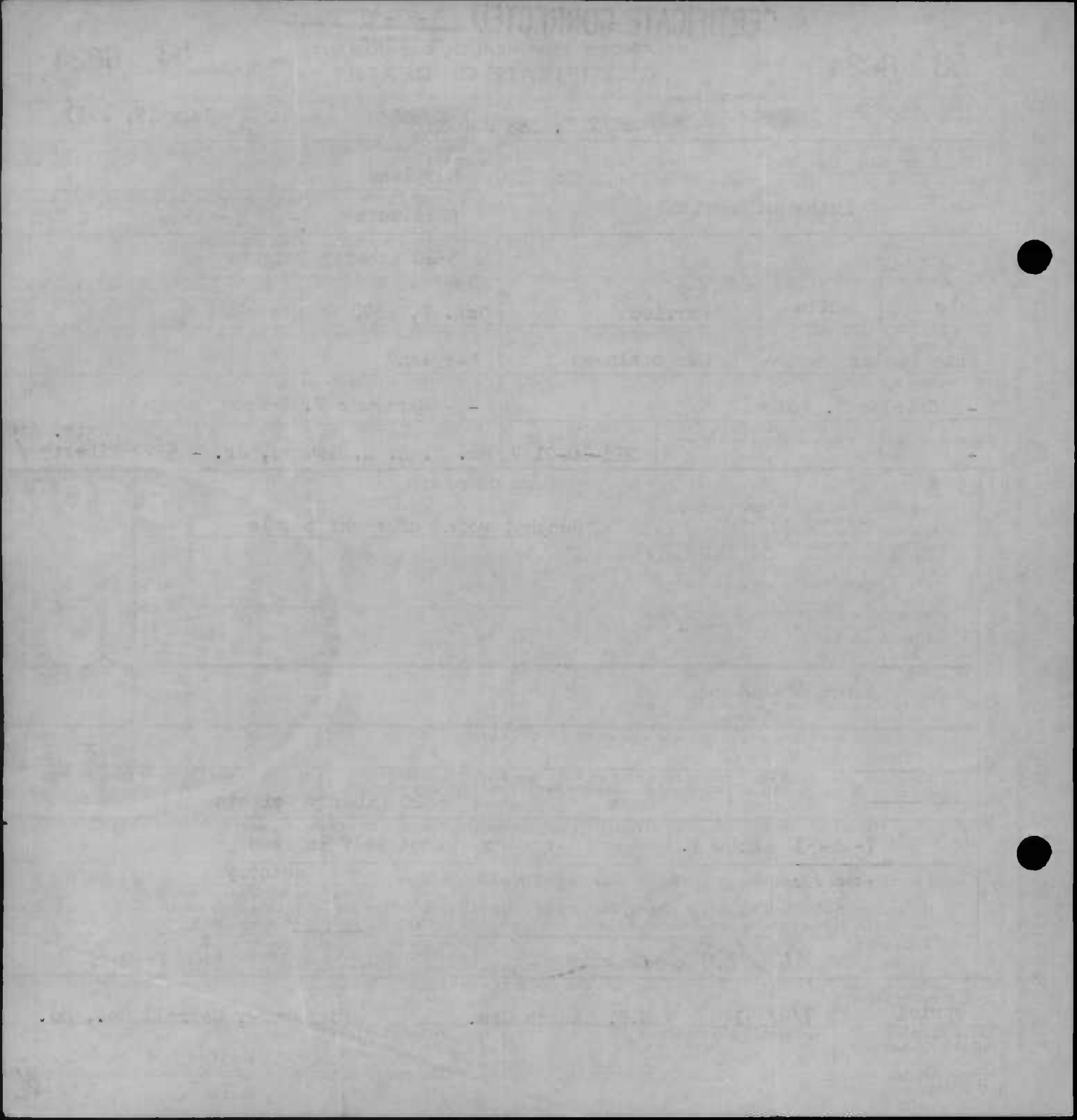
Wm. J. Lickner &amp; Sons

VS 151

N803.4

2906J

Balto 17, Md





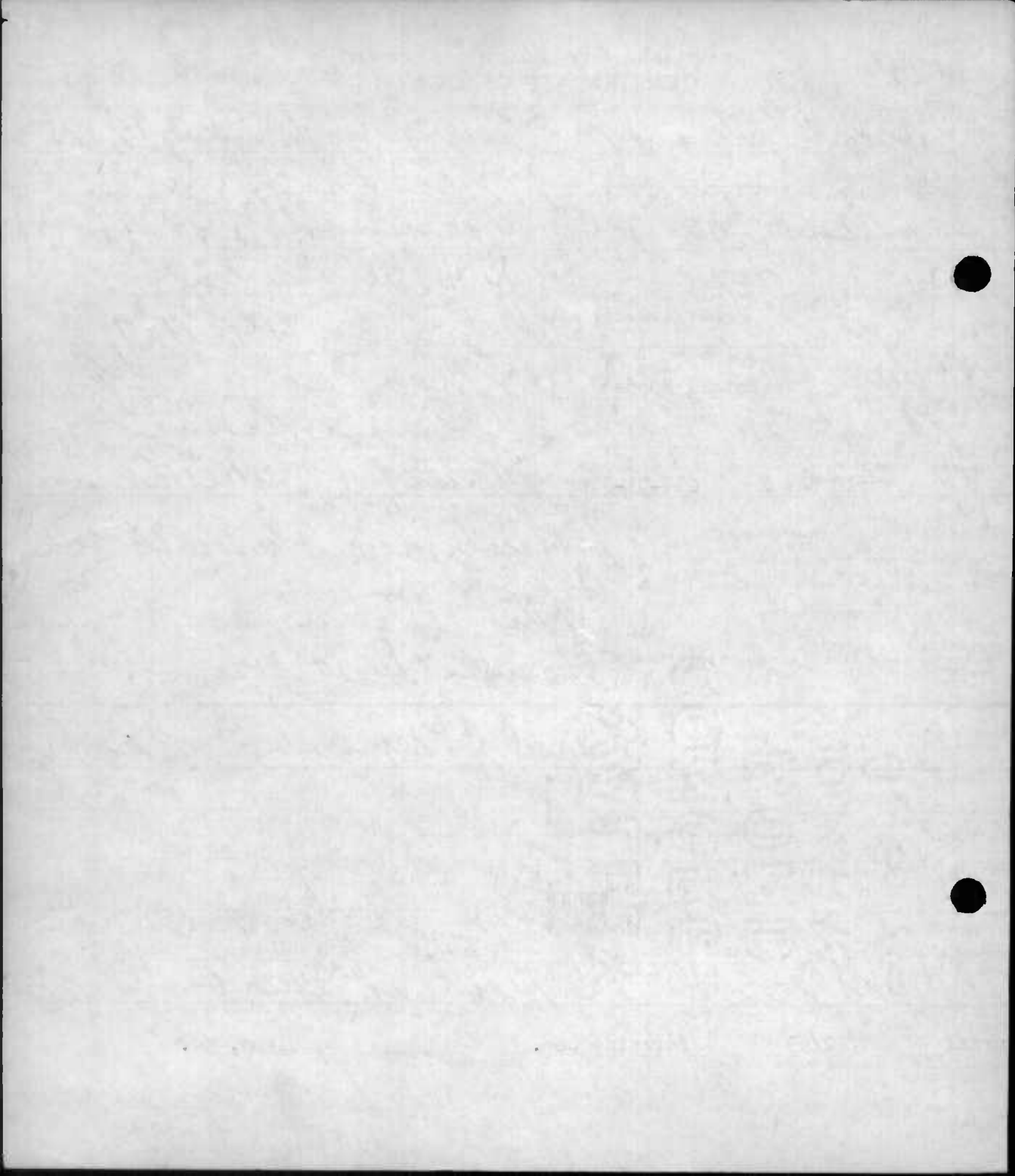
-250

3 6625

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6625

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>or Print <i>Joseph Edward M. Cann</i>  |  | 2. DATE OF DEATH<br><i>July 19, 1953</i>   |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived, in institution, residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |  |
| 5. NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryland General</i>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 28-41</i>                                       |  |
| 6. COLOR OR RACE<br><i>W</i>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  |  |
| 8. DATE OF BIRTH<br><i>July 16, 1903</i>   |  | 9. AGE in years last birthday<br><i>49</i>   |  |
| 10. KIND OF BUSINESS OR INDUSTRY<br><i>Retail Foods</i>  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  |
| 12. CITIZENSHIP<br><i>U.S.</i>   |  | 13. MOTHER'S MAIDEN NAME<br><i>Lorna Kennedy</i>   |  |
| 14. FATHER'S NAME<br><i>Joseph M. Cann</i>   |  | 15. SOCIAL SECURITY NO.<br><i>217-03-3788</i>  |  |
| 16. DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><i>World War 1</i>   |  | 17. INFORMANT<br><i>Roland H. Mueller, Belvedere</i>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Subacute Bacterial Endocarditis</i>          |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>20 days</i>   |  |
| 19. ANTECEDENT CAUSES<br>(DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.)<br><i>Myocardial Stearosis</i>  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Viral Pneumonia</i>  |  | 22. DATE OF OPERATION<br><i>7/22/53</i>  |  |
| 23. MAJOR FINDINGS OF OPERATION<br><i>Myocardial Stearosis</i>   |  | 24. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 25. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 26. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |
| 27. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 28. HOW DID INJURY OCCUR?  |  |
| 29. I hereby certify that I attended the deceased from <i>July 1, 1953</i> to <i>July 19, 1953</i> that I last saw the deceased alive on <i>July 1, 1953</i> and that death occurred at <i>5:45 p.m.</i> from the causes and on the date stated above. |  | 30. SIGNATURE<br><i>Devin Jones</i>  |  |
| 31. ADDRESS<br><i>Maryland General</i>   |  | 32. DATE SIGNED<br><i>July 13, 50</i>  |  |
| 33. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 34. DATE<br><i>7/22/53</i>   |  |
| 35. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Cem.</i>  |  | 36. LOCATION (City, town, or county) (State)<br><i>Woodlawn, Md.</i>   |  |
| 37. RECEIVED BY<br>REGISTRAR<br><i>Huntington Williams</i>   |  | 38. FUNERAL DIRECTOR<br>ADDRESS<br><i>Wm. J. Dickner &amp; Sons</i>  |  |
| 39. VS 150   |  | 40. <i>6446A Route 17, Md.</i>   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6626  
Registered No.53 6626  
BIRTH NO.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MARY ANN DOUGLAS</b>   |                                  |   | 2. DATE OF DEATH<br><b>July 18, 1953</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>Md.</b><br>B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2206 Rosedale St.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                             |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>2206 Rosedale St.</b>  |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>Oct. 27, 1884</b>   |  | 9. AGE (In year: last birthday)<br><b>68</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>               | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>John Lillvik</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Johnson</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>-</b>                                   |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Mr. David G. Douglas-2206 Rosedale St.</b>   |  |  |

|  |  |  |
|--|--|--|
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b><br>DUE TO<br><b>HYPERTENSIVE &amp; ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>CHLORAL DISEASE</b>   |  |  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

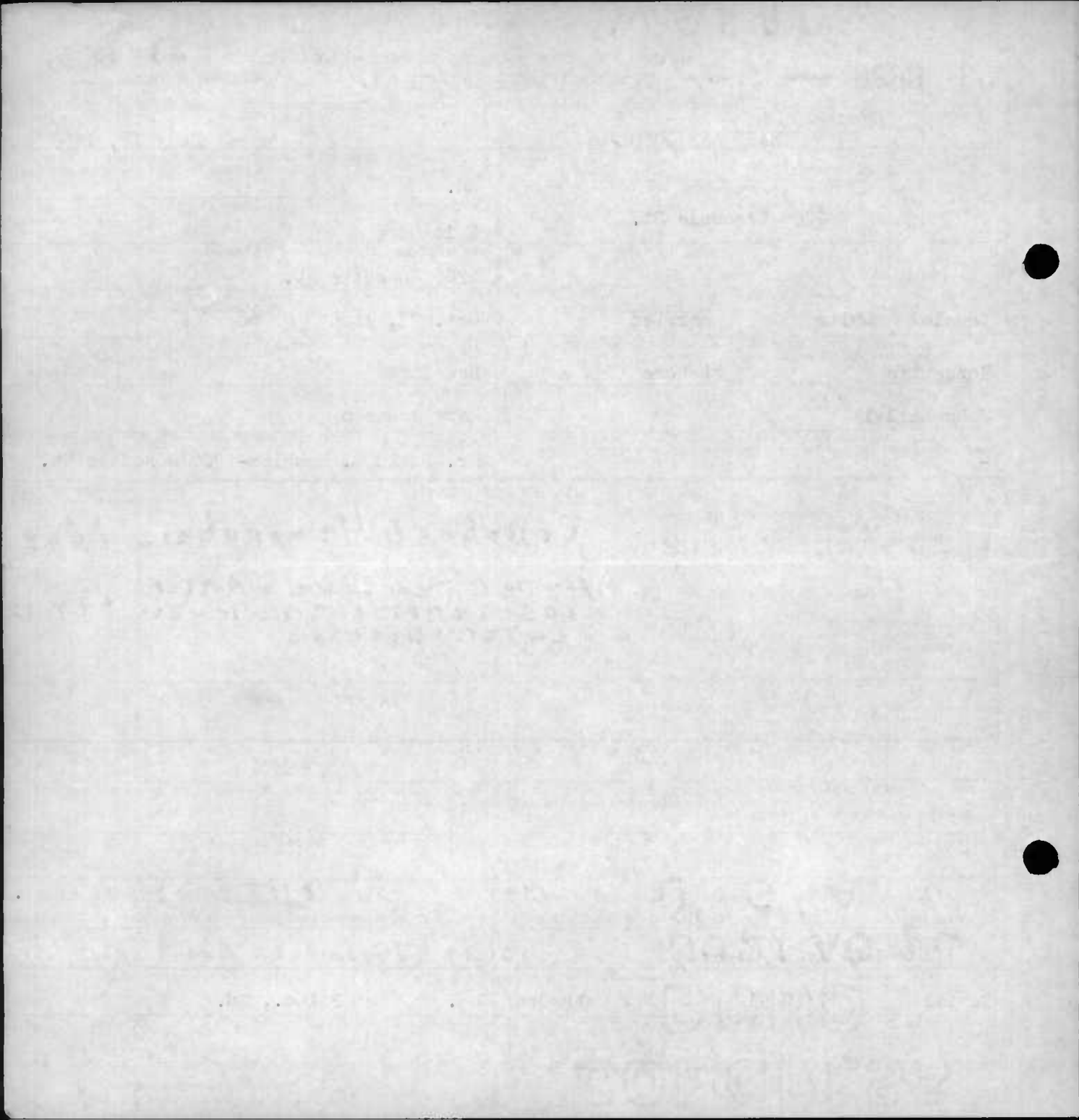
|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **Mar 1, 1953** to **7/18, 1953**, that I last saw the deceased alive on **7/18, 1953**, and that death occurred at **9<sup>45</sup> p.m.**, from the causes and on the date stated above.

|                                       |   |                                    |
|---------------------------------------|---|------------------------------------|
| 22A. SIGNATURE<br><b>Thos G. Rans</b> | 23B. ADDRESS<br><b>3629 Edmondson Ave</b> | 23C. DATE SIGNED<br><b>7/20/53</b> |
|---------------------------------------|---|------------------------------------|

|  |                             |   |   |
|--|-----------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/22/53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |
|--|-----------------------------|---|---|

|  |   |  |                                  |
|--|---|--|----------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 21 1953</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Wm. J. Vickner &amp; Sons</b> | ADDRESS<br><b>Balto. 17, Md.</b> |
|--|---|--|----------------------------------|



2-200  
53 6627

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6627  
Registered No.

TH NO.

NAME OF DECEASED (Last, first, middle, or Print) **DR. FRANCIS J. B. LUKE** 2. DATE OF DEATH **7-19-53**

PLACE OF DEATH: **Baltimore City, Maryland** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MD.** B. COUNTY **BALTO.**

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) **1501 E. EAGER ST.** C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) **BALTO.**

DATE OF DEATH **7-19-53** D. STREET ADDRESS (If rural, give location) **1501 E. EAGER ST.**  
Length of stay in Baltimore **15 YRS.** 8. DATE OF BIRTH **2-22-1900** 9. AGE (In years last birthday) **53**

EX. 6. COLOR OR RACE **C.** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **MARRIED** 10. KIND OF BUSINESS OR INDUSTRY **PHYSICIAN**

11. BIRTHPLACE (State or foreign country) **TRINIDAD, B.W. I.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

FATHER'S NAME **JOSEPH J. B. LUKE** 14. MOTHER'S MAIDEN NAME **F. MC CLELLAN**

17. INFORMANT **MARJORIE LUKE** ADDRESS **1501 E. EAGER ST.**

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **07585**

3. **420.1** I **I** CAUSE OF DEATH **Coronary Thrombosis** INTERVAL BETWEEN ONSET AND DEATH **15 mins**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) **Coronary Thrombosis** DUE TO

ANTECEDENT CAUSES (B) **Acute Myocarditis** DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION **7-22-53** 19b. MAJOR FINDINGS OF OPERATION **Acute Myocarditis** 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **Home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1D. TIME (Month) (Day) (Year) (Hour) **7/19/53 8:10 P.M.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from **6/18/53** to **July 19, 1953** that I last saw the deceased alive on **7/19/53** and that death occurred at **8:10 P.M.** from the causes and on the date stated above.

3A. SIGNATURE **Robert A. DeForest** M. D. **822 N. Bond St.** 23C. DATE SIGNED **7/24/53**

BURIAL, CREMATION, REMOVAL (Specify) **ORIGINAL** 24B. DATE **7-22-53** 24C. NAME OF CEMETERY OR CREMATORY **ARBUTUS MEM. PK.** 24D. LOCATION (City, town, or county) (State) **ARBUTUS, MD.**

RECEIVED BY REGISTRAR'S SIGNATURE **Joseph H. Locks** 25. FUNERAL DIRECTOR **1304 N. Central Ave.**

VS 1501 1953 Huntington, William **07585**

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1953

Form No. 10-50

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Immediate cause

9. Underlying cause

10. Manner of death

11. Signature of physician

12. Signature of medical examiner

13. Signature of coroner

14. Signature of registrar

15. Signature of informant

16. Signature of witness

17. Signature of funeral director

18. Signature of undertaker

19. Signature of cemetery

20. Signature of burial place



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. <sup>53</sup> 6628

BIRTH NO.

53 6628

1. NAME OF DECEASED  
(Type or Print)

CATHERINE DORSEY

2. DATE OF DEATH July 16, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-02

D. STREET ADDRESS (If rural, give location)

1628 McCulloh Street

C. Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

*July 25/22 30*

9. AGE (In years last birthday)

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Domestic*

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTH PLACE (State or foreign country)

*Baltimore Md*

13. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Walter Meades*

14. MOTHER'S MAIDEN NAME

*Sister Shapson*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*James Meades*

ADDRESS

18. E 903.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

*Subdural hemorrhage*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

*Home*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

*1628 McCulloh Street*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

*June 1953*

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Had migraine headache and fell down*

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William J. ...*

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

*July 16, 1953*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*7/21/53*

24C. NAME OF CEMETERY OR CREMATORY

*Putnam Cal Brooklyn N.Y.*

24D. LOCATION (City, town, or county)

*Brooklyn N.Y.*

(State)

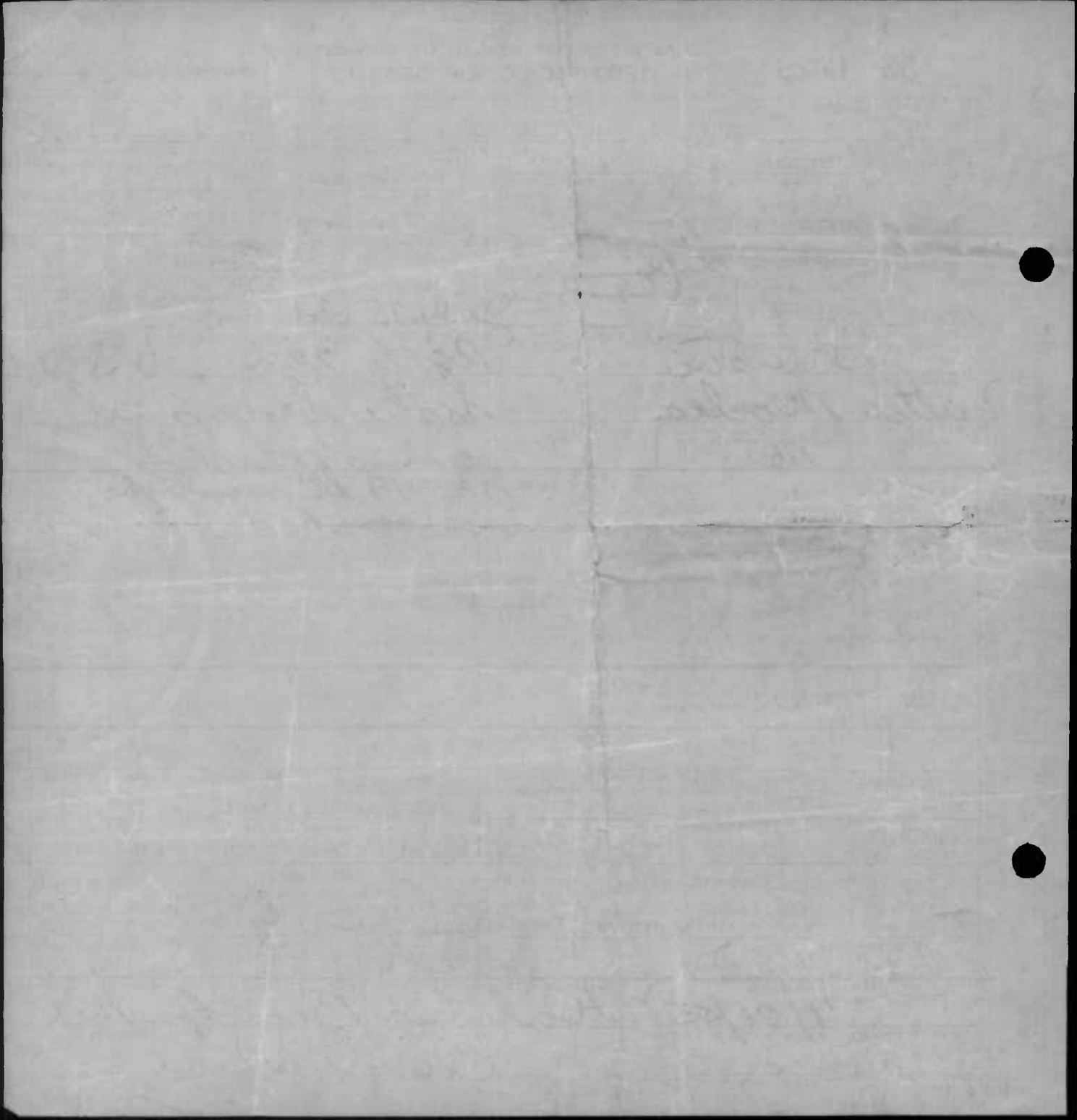
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Clayton Wilson*



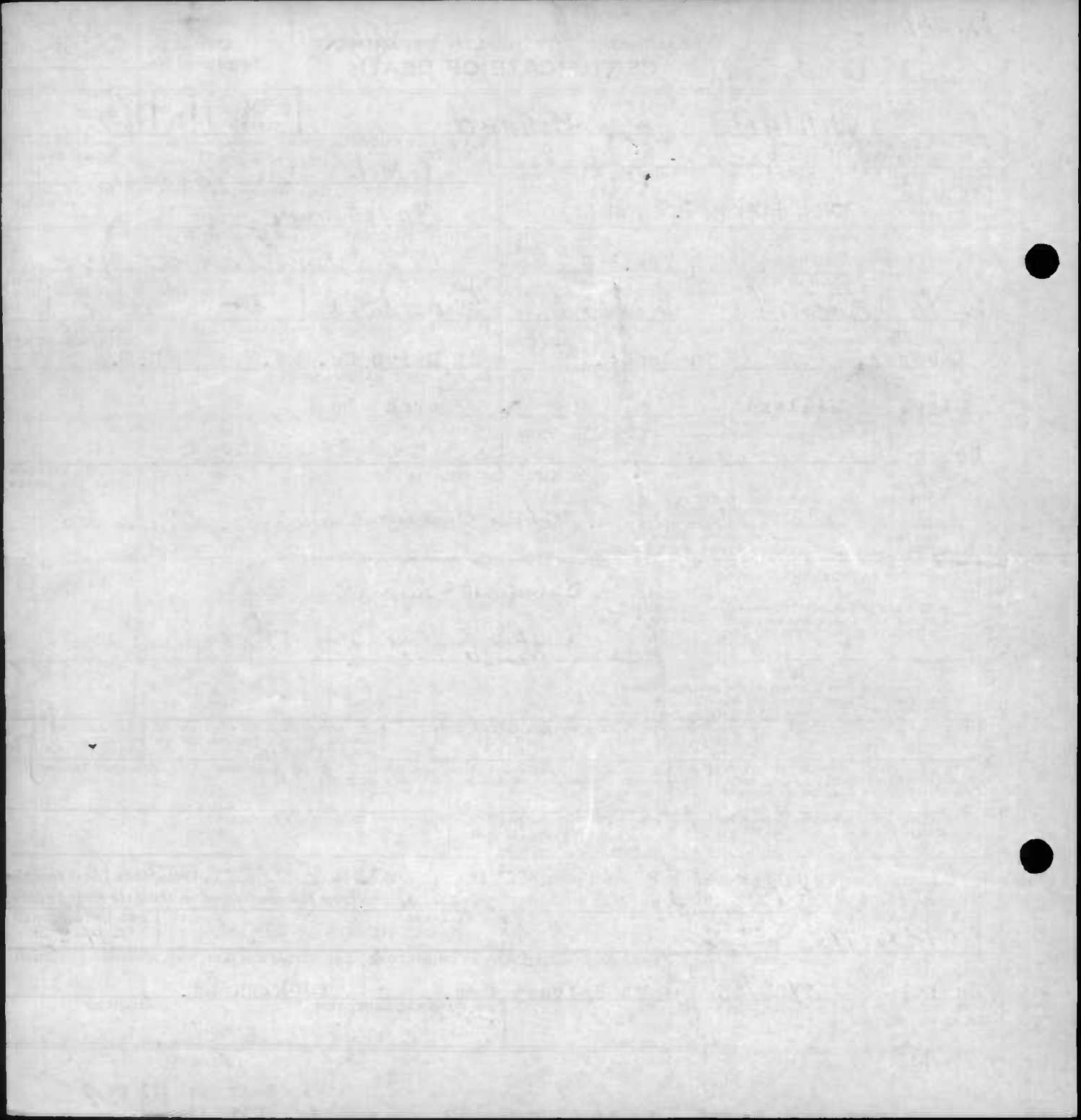
M-463

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6629  
Registered No.

BIRTH NO. 53 6629

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William Millard</b>   |  | 2. DATE OF DEATH <b>JUL 19 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Med. Cpl 2</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>                         |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1728 Ashland Ave</b>  |  | 6. DATE OF BIRTH <b>Feb. 16, 88</b>   |  |
| 7. SEX <b>male</b>  |  | 8. AGE (In years last birthday) <b>65</b>   |  |
| 9. COLOR OR RACE <b>colored</b>   |  | 10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>Sippi Millard</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Sarah Bush</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>   |  | ADDRESS   |  |

|  |   |  |
|--|---|--|
| 18. <b>715X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Diffuse Bronchopneumonia</b><br>CAUSE OF DEATH<br>DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>ca 10d</b>  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Innervation? hyperalbuminemia</b><br>DUE TO<br><b>Diffuse Bullous Dermatitis + severe diabetes ulcers</b>                             |   | <b>2 mo.</b>   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |
| 19A. DATE OF OPERATION <b>7/19/53</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                 |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>6-6-</b> , 19 <b>53</b> to <b>7-19-</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7-19-</b> , 19 <b>53</b> , and that death occurred at <b>2 A</b> m., from the causes and on the date stated above.   |   |  |
| 23A. SIGNATURE <b>T. A. Mc Intyre</b>  | 23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>  | 23C. DATE SIGNED <b>7-19-53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 24B. DATE <b>7/23/53</b>  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>                                |
| 24D. LOCATION (City, town, or county) <b>Brooklyn Md.</b>  | 24E. FUNERAL DIRECTOR <b>Elmer W. Wilson</b>  | 24F. ADDRESS <b>1100 Beaulieu ave</b>  |



PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| BALTIMORE CITY HEALTH DEPARTMENT  |                                 | Registered No. <b>53 6630</b>   |   |
|---|---------------------------------|---|---|
| CERTIFICATE OF DEATH  |                                 |   |   |
| BIRTH NO. <b>517 15372</b>  |                                 |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Benedict McFadden</b>   |                                 | 2. DATE OF DEATH <b>July 19, 1953</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Red. H. L. 34</b>  |                                 | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>md.</b>      |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>   |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 31 7-0</b>           |   |
| c. Length of stay in Baltimore <b>5 1/2</b> Yrs. Mos. Days  |                                 | D. STREET ADDRESS (If rural, give location)<br><b>903 N. Broadway</b>   |   |
| 5. SEX <b>Female Colored</b>  | 6. COLOR OR RACE <b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>   | 8. DATE OF BIRTH <b>7-7-51</b>                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>   |                                 | 10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>   | 9. AGE (In years last birthday) <b>2</b>          |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>Larry McFadden</b>   |                                 | 14. MOTHER'S MAIDEN NAME <b>Eula Mae?</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>  |                                 | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>   |                                 | ADDRESS <input checked="" type="checkbox"/>   |   |
| 18. <b>E885.0</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH.<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Lead Encephalopathy</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>Lead ingestion</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>CERTIFICATION APPROVED BY J. B. Fisher M.D.</b> |                                 |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| 19A. DATE OF OPERATION <b>7</b>   |                                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>   |                                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>              |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-17-53</b> m.   |                                 | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |   |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>903 N. Broadway</b>  |                                 | 21F. HOW DID INJURY OCCUR?<br><b>apparently ingested lead</b>   |   |
| 22. I hereby certify that I attended the deceased from <b>7-17</b> , 1953, to <b>7-18</b> , 1953, that I last saw the deceased alive on <b>7-18</b> , 1953, and that death occurred at <b>6:35 P.M.</b> , from the causes and on the date stated above.   |                                 |   |   |
| 23A. SIGNATURE <b>[Signature]</b> M.D.  |                                 | 23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>  |   |
| 23C. DATE SIGNED <b>7/19/53</b>   |                                 |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                 | 24B. DATE <b>7/23/53</b>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Kingslee</b>  |                                 | 24D. LOCATION (City, town, or county) (State) <b>Kingslee S.C.</b>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                 | 25. FUNERAL DIRECTOR'S ADDRESS<br><b>Elroy O. Wilson 1045 Brantley</b>  |   |
| REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                                 |   |   |
| <p><b>Medical Examiner to approve Certificate</b></p> <p><b>VS-150 N966.0</b></p> <p><b>21 1953</b></p>   |                                 |   |   |

10

2

2



A-536  
53 6631BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6631  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sadie E. J. Anderson

2. DATE  
OF  
DEATH

JUL 20 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Order 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 12-03

D. STREET ADDRESS (If rural, give location)

2418 Gilford Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female Colored

Married

8. DATE OF BIRTH

Nov-24-07

9. AGE (In years  
last birthday)

46

If Under 1 Year  
Months: Days  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Dorsey

14. MOTHER'S MAIDEN NAME

Daisy Kees

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocardial Infarction

36 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerotic Card. vas. Dis.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20-1953 to 7-20-1953 that I last saw the  
deceased alive on 7-20-1953, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

W.E. Madison Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/20/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/23/53

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Arbutus Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Elroy O. Wilson

ADDRESS

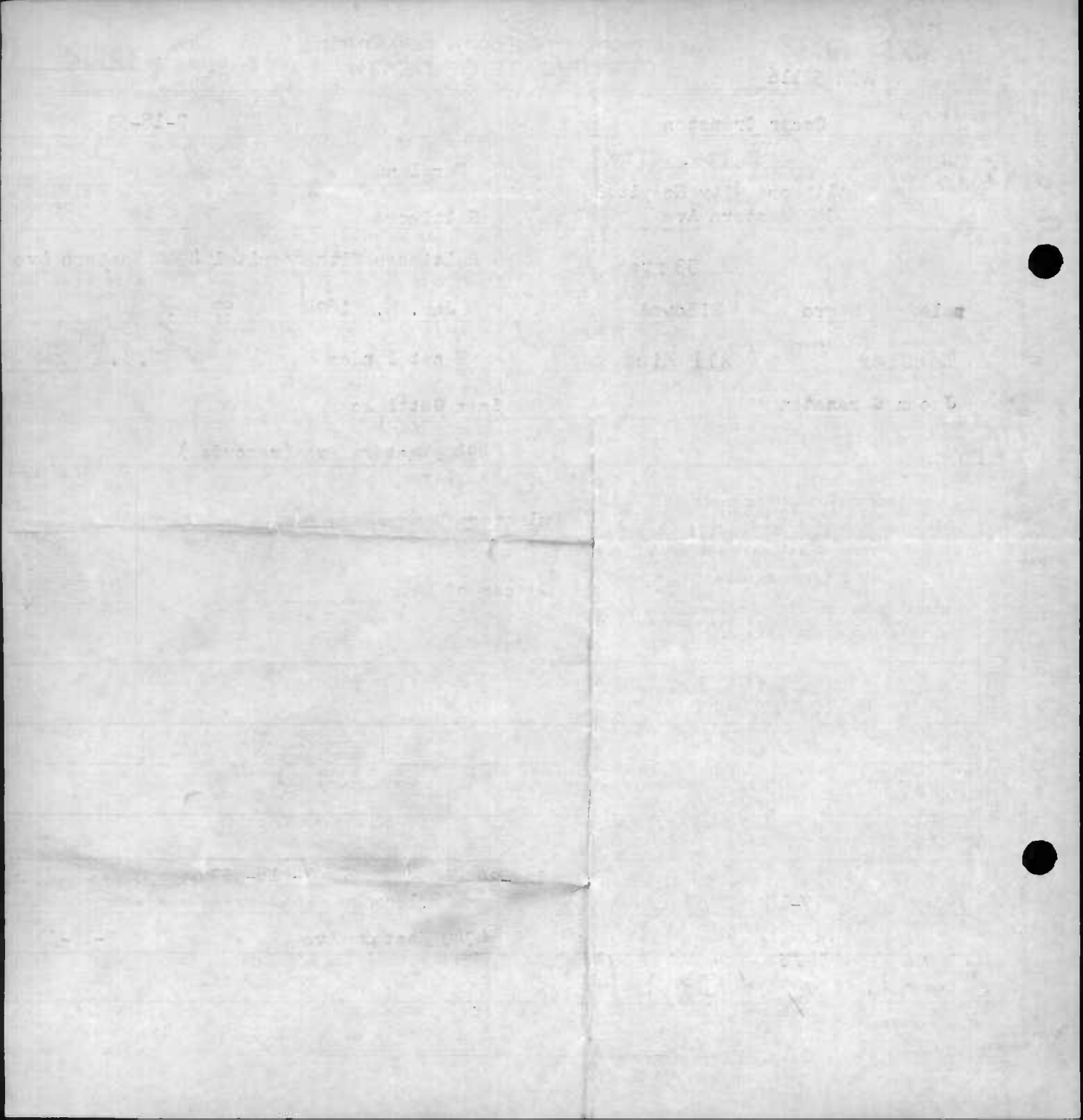
1100 Buntly  
ave



MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| BALTIMORE CITY HEALTH DEPARTMENT  |                                  |   |   | Registered No. <b>53 6632</b>   |   |
|---|----------------------------------|---|---|---|---|
| CERTIFICATE OF DEATH  |                                  |   |   |   |   |
| BIRTH NO. <b>53 6632</b><br><b>Ajh 52116</b>  |                                  |   |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Oscar Cranston</b>  |                                  |   | 2. DATE OF DEATH <b>7-18-53</b>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Ave</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>26-12</b>     |   |   |
| c. Length of stay in Baltimore <b>33 yrs</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>Baltimore Cith Hospital 4940 Eastern Ave</b>                    |   |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>Jan. 6. 1894</b>   | 9. AGE (In years last birthday)<br><b>59</b>                                  | If Under 1 Year Months Days<br>If Under 24 Hours Hours Min.         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>West I ndes</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                        |
| 13. FATHER'S NAME<br><b>J ohn C ranston</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Inez Gettings</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>4940 Eastern Ave (records )</b>   |   |   |
| 18. <b>163X</b> CAUSE OF DEATH  |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH                                    |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Pulmonary Hemorrhage</b><br>DUE TO  |                                  |   |   |   |   |
| ANTECEDENT CAUSES<br><b>(B) Cancer of Lung</b><br>DUE TO  |                                  |   |   |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(C)</b>   |                                  |   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |   |   |
| 19A. DATE OF OPERATION <b>7</b>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II        |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?      |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>1 -20 40</b> , 19 <b>40</b> , to <b>7-18-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-18</b> , 19 <b>53</b> , and that death occurred at <b>8.10am.</b> , from the causes and on the date stated above. |                                  |   |   |   |   |
| 23A. SIGNATURE <b>H. J. Wilson</b> M. D.  |                                  |   | 23B. ADDRESS<br><b>4940 Eastern Ave</b>   |   | 23C. DATE SIGNED<br><b>7-18-53</b>                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7/24/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>mt calvary cem</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Brooklyn Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |   | 25. FUNERAL DIRECTOR<br><b>Felipe O. Wilson</b> ADDRESS<br><b>1100 Brandy</b> |   |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6633**

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

**WILLIAM H. BLANCHARD, JR.**

2. DATE  
OF  
DEATH

**7.19.1953**

PLACE OF DEATH:

Baltimore City, Maryland

3. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

**1422 COVINGTON ST.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**BALTIMORE 24-02**

D. STREET ADDRESS (If rural, give location)

**1422 COVINGTON ST.**

6. Length of stay in Baltimore

**70-Yrs.  
Mos.  
Days**

SEX

6. COLOR OR RACE

**W.**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Widower**

8. DATE OF BIRTH

**Sept. 13-1877**

9. AGE (In years last birthday)

**75**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

**Freight Grocer**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**MD.**

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

**William H. Blanchard Sr.**

14. MOTHER'S MAIDEN NAME

**MARY Shelby**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

**None**

17. INFORMANT

ADDRESS

**C. MADELINE BLANCHARD 1422 Covington St.**

18. **16XX**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

**Carcinoma of lung (pt.)  
- Metastasis**

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20. DATE OF OPERATION

21. MAJOR FINDINGS OF OPERATION

22. AUTOPSY?

YES ☐ NO ☒

23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

24. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

26. TIME (Month) (Day) (Year) (Hour) OF INJURY

27. INJURY OCCURRED

28. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

29. I hereby certify that I attended the deceased from **5/25/53**, 19**53**, to **7/19/**, 19**53** that I last saw the deceased alive on **7/18/**, 19**53**, and that death occurred at **330A.M.**, from the causes and on the date stated above.

30. SIGNATURE

**N. P. Friedman**

31. ADDRESS

**1319 Lister St.**

32. DATE SIGNED

**7/24/53**

33. BURIAL, CREMATION, REMOVAL (Specify)

34. DATE

35. NAME OF CEMETERY OR CREMATORY

36. LOCATION (City, town, or county) (State)

37. RECEIVED BY

REGISTRAR'S SIGNATURE

38. FUNERAL DIRECTOR

ADDRESS

39. AL REGISTRAR

40. REGISTRAR'S SIGNATURE

41. FUNERAL DIRECTOR

ADDRESS

42. DATE

43. REGISTRAR'S SIGNATURE

44. FUNERAL DIRECTOR

ADDRESS

45. DATE

46. REGISTRAR'S SIGNATURE

47. FUNERAL DIRECTOR

ADDRESS

48. DATE

49. REGISTRAR'S SIGNATURE

50. FUNERAL DIRECTOR

ADDRESS

51. DATE

52. REGISTRAR'S SIGNATURE

53. FUNERAL DIRECTOR

ADDRESS

Dr Friedman  
Light St



- 200

53 6634

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6634

IRTH NO.

NAME OF DECEASED  
(Name or Print)

Emma Chase

2. DATE  
OF  
DEATH

7-18-53

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
STITUTION

Lincoln Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
310 N. Schroeder St

Length of stay in Baltimore

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)10a. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

John H Howard

14. MOTHER'S MAIDEN NAME

Annie Goldsboro

13. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Sallie Anderson - 11297 Guilford

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-15, 1952, to 7-18, 1952, that I last saw the  
deceased alive on 7-15, 1952 and that death occurred at 10 m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

A. BURIAL, CREMA-  
N, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

7208A

1010 N. Caling. Ter. dr.

5-18-23

James H. Hester

Age 65

James H. Hester

510 W. 1st Street

May 30 - 1923

4

2

4

James H. Hester

James H. Hester

James H. Hester  
5-20-23

53 6635

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6635

IRTH NO.

NAME OF DECEASED  
(Type or Print)

Bertha Baker

2. DATE  
OF  
DEATH

7-19-53

PLACE OF DEATH:  
Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
STATION

2800 Windsor Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balt

15-47

Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2800 Windsor Ave

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

14. MOTHER'S MAIDEN NAME

13. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 171X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Toxin + Infection

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from April 1953, to July 19, 1953, that I last saw the  
deceased alive on July 19, 1953, and that death occurred at 10:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

13

7-23-23

Chitao

1011 W. Columbia St.  
Lawrence H. Williams Jr.  
Chitao

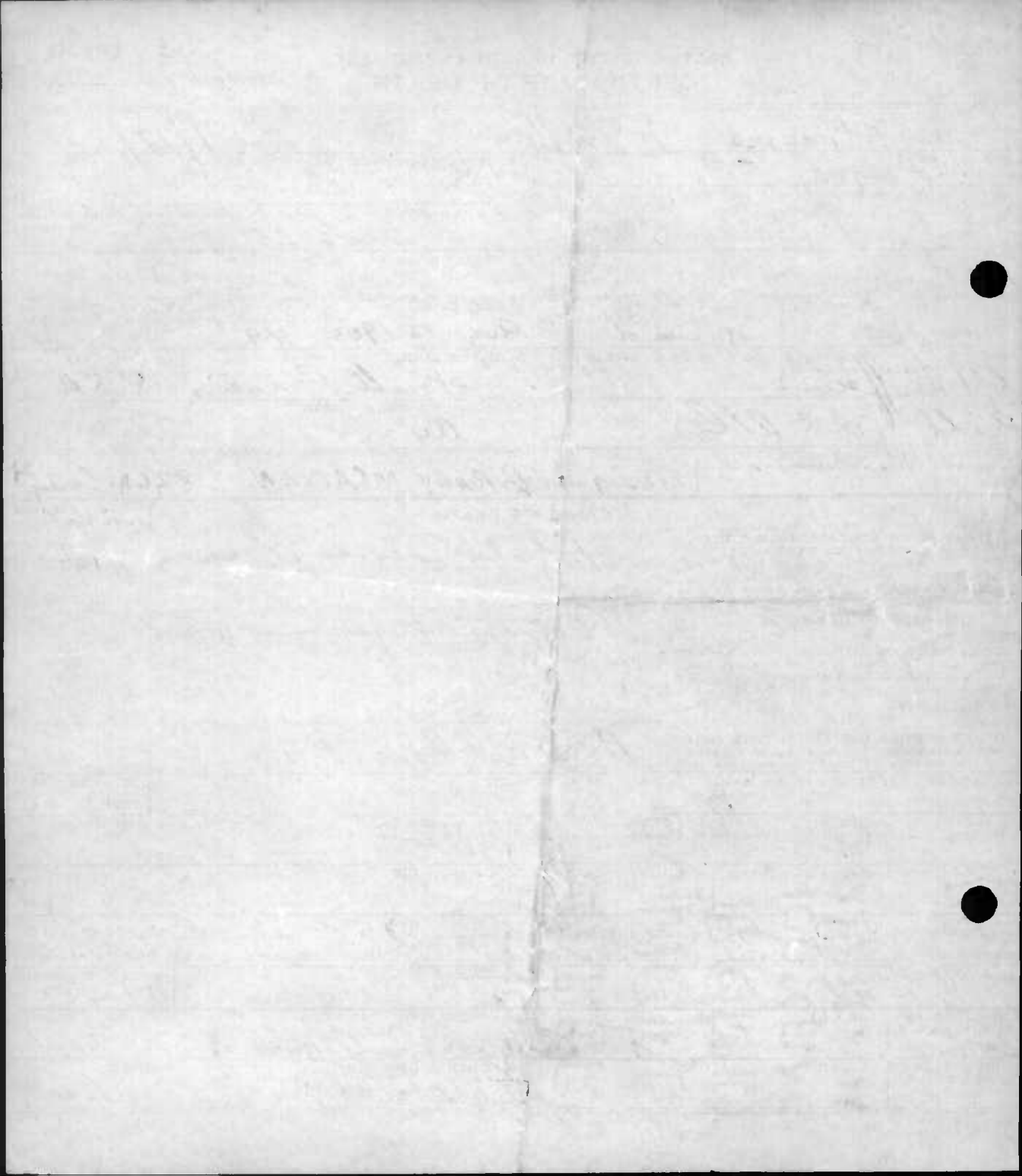
-245  
53 6636BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6636  
Registered No.

TH NO.

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED (Last, first, middle or Print)  |  | 2. DATE OF DEATH   |  |
| Stingree McAllen   |  | 7/19/53  |  |
| PLACE OF DEATH: Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived before admission):<br>A. STATE M1 B. COUNTY |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)         |  |
| 27 N. Carey St.  |  | Baltimore 18-02  |  |
| HOSPITAL OR INSTITUTION  |  | D. STREET ADDRESS (If rural, give location)  |  |
| 27 N. Carey St.  |  |  |  |
| Years of stay in Baltimore   |  | 8. DATE OF BIRTH   |  |
| Yrs. Mos. Days   |  | Aug. 15, 1903  |  |
| 6. COLOR OR RACE   |  | 9. AGE (At year, last birthday)  |  |
| Maca Negro   |  | 49   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  | 11. BIRTHPLACE (State or foreign country)  |  |
| Married  |  | South Carolina   |  |
| 10. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Charwoman  |  | USA  |  |
| FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  |
| Bill McAllen   |  | Agnes  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)        |  | 16. SOCIAL SECURITY NO.  |  |
| No or unknown  |  | 218-09-124   |  |
| 17. INFORMANT  |  | ADDRESS  |  |
| GRADY MCALLEN  |  | 826 N. Carey St.   |  |

|  |  |                                |  |                                  |  |
|--|--|--------------------------------|--|----------------------------------|--|
| 8. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH                 |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES  |  | (A) Acute Coronary Occlusion   |  | 7/18/53                          |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) Chronic Myocardial Disease |  |                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | (C) Essential Hypertension     |  |                                  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 9A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 1A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 1D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 2. I hereby certify that I attended the deceased from March 1952, to July 18, 1953, that I last saw the deceased alive on July 18, 1953, and that death occurred at 5:05 p.m., from the causes and on the date stated above. |  |  |  |  |  |
| 3A. SIGNATURE  |  | 23B. ADDRESS   |  | 23C. DATE SIGNED   |  |
| Robert L. Haney  |  | 222 N. Fulton Ave  |  | 7/20/53  |  |
| BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial   |  | 7/22/53  |  | Mt. Calvary  |  |
| RECEIVED BY AL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR   |  |
| Huntington Williams  |  | Charles C. Rice  |  | 661 W. Bore  |  |
| VS 150 24 1953 68399   |  |  |  |  |  |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6637  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AARON JACKSON

2. DATE  
OF  
DEATH

7/18/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

700 Fleet St.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 22-02

d. STREET ADDRESS (If rural, give location)

650 Houser st

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Col

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 26, 1898 54

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Freeman

10b. KIND OF BUSINESS OR  
INDUSTRY

Western Md. R.R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Grant Jackson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Estelle Jackson 650 Houser st

18. E929.8

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

DROWNING

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Coal Pier

21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Port Covington Terminal, West. Md. R.R.

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 18, 1953 5: P

21e. INJURY OCCURRED

IN

WHILE AT

WORK

NOT WHILE

AT WORK

21f. HOW DID INJURY OCCUR?

Thrown overboard when cable slipped.

22. I certify that I took charge of the remains described above, held an **PARTIAL AUTOPSY** thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Joseph A. Jachimczyk M.D.

23b. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

23c. DATE SIGNED

7-19-53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

7/23/53

24c. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24d. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hall

25. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Bayne

V.S. 151

N 990x

54250

1938

OFFICIAL OF THE

WILLIAM A. JONES

7

DISCOUNT

1938

WILLIAM A. JONES

C-620

53 338

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6638

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SADYE A. CHARSHÉE

2. DATE  
OF  
DEATH

JULY 19, 1953

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTO

12-02

D. STREET ADDRESS (If rural, give location)

334 E. UNIVERSITY

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JAN. 29 1876

9. AGE (In years  
last birthday)

77

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HAYDEN

14. MOTHER'S MAIDEN NAME

ADELAIDE BISCOE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ARTHUR V. CHARSHÉE

ADDRESS

ABOVE

18. 467.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypostatic Pneumonia.

DUE TO

24 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Confined to bed.

DUE TO

(C) Vascular changes.

Several  
days.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

None

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945 to July 19, 1953 that I last saw the  
deceased alive on July 19, 1953, and that death occurred at 1030 P. M., from the causes and on the date stated above.

23A. SIGNATURE

W. H. Jenkins

23B. ADDRESS

3005 B. Paul St.

23C. DATE SIGNED

July 20, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

7-22-1953

24C. NAME OF CEMETERY OR CREMATORY

WOODLAWN

24D. LOCATION (City, town, or county)

WOODLAWN

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

H. W. JENKINS &amp; SONS CO. 4905 YORK RD.

DR KELSO WHITE

3005 ST PAUL ST

520

3 6639

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6639

NAME OF DECEASED (Last, first, middle, or Print) **SHIMUCK, ANTON O.**

2. DATE OF DEATH **July 19, 1953**

PLACE OF DEATH: **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**BALTIMORE, MARYLAND**

D. STREET ADDRESS (If rural, give location)  
**605 S. Paca St. 22-02**

5. Usual place of stay in Baltimore

6. COLOR OR RACE **White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Married**

8. DATE OF BIRTH  
**July 23 1892**

9. AGE (In years last birthday) **60**

10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  
**Presser on Mens Coats**

10a. KIND OF BUSINESS OR INDUSTRY  
**Tailor Shop**

11. BIRTHPLACE (State or foreign country)  
**RUSSIA**

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME  
**Onesia Shimuck**

14. MOTHER'S MAIDEN NAME  
**Sophia Matrink**

17. INFORMANT ADDRESS  
**John Shimuck 1418 Belt St.**

18. **581.1**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Liver Insufficiency (Cirrhosis)**

CAUSE OF DEATH  
(A) **Due to**  
(B) **Laennec's Portal Cirrhosis**  
(C)

INTERVAL BETWEEN ONSET AND DEATH  
**7-19-53**  
**1945 to 7-19-53**

19. DATE OF OPERATION **0**

19A. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 2nd**, 1953, to **July 19**, 1953, that I last saw the deceased alive on **July 19**, 1953, and that death occurred at **8:25 Am.**, from the causes and on the date stated above.

23A. SIGNATURE  
**Joseph Louis Jerney, M.D.**

23B. ADDRESS  
**SOUTH BALTIMORE GENERAL HOSPITAL**

23C. DATE SIGNED  
**7-19-53**

24. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE  
**July 23 1953**

24C. NAME OF CEMETERY OR CREMATORY  
**RUSSIAN CEMETERY**

24D. LOCATION (City, town, or county) (State)  
**Ort. Elkridge Md.**

25. FUNERAL DIRECTOR ADDRESS  
**Frank DellaVoe 322 S. High St.**

VS 150

6906E

1940

CERTIFICATE OF DEATH

1940

John William Davis



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6640

Registered No. \_\_\_\_\_

BIRTH NO. 53 6640

|  |                           |   |   |  |                                  |
|--|---------------------------|---|---|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)   |                           | Lillian P. Bullen   |   | 2. DATE OF DEATH<br>July 20, 1953  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore |  |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>1235 Haverhill Road   |                           |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 25-41                                   |  |                                  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           |   | D. STREET ADDRESS (If rural, give location)<br>1235 Haverhill Road  |  |                                  |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married                                | 8. DATE OF BIRTH<br>Sept. 12, 1890  | 9. AGE (In years, last birthday)<br>62                                   | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>own home   | 11. BIRTHPLACE (State or foreign country)<br>Prince Georges County, Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?     |
| 13. FATHER'S NAME<br>Harry Jones   |                           |   | 14. MOTHER'S MAIDEN NAME<br>---   |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                           | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br>Louis F. Bullen, 1235 Haverhill Road   |  |                                  |
| 18. 170X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Advanced Carcinoma of left Breast with metastases<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>6 months<br>1 yr. ±   |  |                                  |
| 19A. DATE OF OPERATION   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK                                      |   | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from June 1953, to July 20, 1953, that I last saw the deceased alive on July 20, 1953, and that death occurred at 11:30 A. M., from the causes and on the date stated above.   |                           |   |   |  |                                  |
| 23A. SIGNATURE<br>D. D. M. P.  |                           | 23B. ADDRESS<br>642 W. N. B. 1/4  |   | 23C. DATE SIGNED<br>7-21-53  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                           | 24B. DATE<br>7/23/53  |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery               |                                  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland   |                           | 24E. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                |   | 24F. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland     |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 27 1953  |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |   | 25. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook, Inc., 1217 St. Paul Street     |                                  |

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3 6641

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6641  
Registered No.

|  |                              |  |   |
|--|------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)<br><b>Mrs. Lucy CORTEGGIANO (CORTEGGIANO)</b>   |                              | 2. DATE OF DEATH<br><b>7/20/53</b>   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Baltimore</b> |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MERCY HOSP INC</b>   |                              | C. CITY OR TOWN<br><b>Balto</b>  |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>40</b> Days   |                              | D. STREET ADDRESS (If rural, give location)<br><b>6905 Linden Ave Overlea</b>  |   |
| 7. SEX<br><b>F</b>   | 8. COLOR OR RACE<br><b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 10. DATE OF BIRTH<br><b>Jan. 3rd 1893</b> |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Housewife</b>  |                              | 12. AGE (In years last birthday)<br><b>60</b>  |   |
| 13. FATHER'S NAME<br><b>Michael De Vincentiis</b>  |                              | 14. BIRTHPLACE (State or foreign country)<br><b>Italy</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Ada Magnani</b>  |                              | 18. ADDRESS<br><b>6905 Linden Ave Overlea</b>  |   |
| 19. CAUSE OF DEATH<br>A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Accident</b><br>B. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerosis associated with Diabetes Mellitus</b> |                              | 20. INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>  |   |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                              |  |   |
| 22. DATE OF OPERATION<br><b>7/8/53</b>   |                              | 23. MAJOR FINDINGS OF OPERATION<br><b>FRACTURE OF LEFT Femur</b>   |   |
| 24. DATE OF ACCIDENT OR CONTRIBUTING CAUSE OF DEATH<br><b>7/7/53</b>   |                              | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                     |   |
| 26. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>7/7/53 ? m.</b>   |                              | 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>6 Eleanor St.</b>  |   |
| 28. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>7/7/53 ? m.</b>   |                              | 29. HOW DID INJURY OCCUR?<br><b>walking down the stairs</b>  |   |
| 30. I hereby certify that I attended the deceased from <b>7/3/53</b> , 19 <b>53</b> , to <b>7/20</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>53</b> , and that death occurred at <b>1:15 p.m.</b> , from the causes and on the date stated above.   |                              |  |   |
| 31. SIGNATURE<br><b>Carvallin, M.D.</b>  |                              | 32. DATE SIGNED<br><b>7/20/53</b>  |   |
| 33. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 34. DATE<br><b>July 23 1953</b>  |   |
| 35. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                              | 36. LOCATION (City, town, or county) (State)<br><b>3310 Taylor Ave Balt. Md.</b>   |   |
| 37. RECEIVED BY<br><b>Huntington Williams, M.D.</b>  |                              | 38. FUNERAL DIRECTOR<br><b>Parrell DellaNoce</b>   |   |
| 39. ADDRESS<br><b>322 S. High St.</b>  |                              | 40. ADDRESS  |   |

VS 150  
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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

NEW YORK

536

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6642

3-6642

|   |                             |  |  |  |  |
|---|-----------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>William H. Anderson</i>   |                             |  | 2. DATE OF DEATH <i>July 20 '53</i>  |  |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland <i>Baltimore Maryland</i>  |                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |  |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>Maryland general Hospital</i> |                             |  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-02</i>                                       |  |  |
| 7. Length of stay in Baltimore <i>life</i>  |                             |  | 8. STREET ADDRESS (If rural, give location)<br><i>2603 1st ave #14</i>   |  |  |
| 9. SEX <i>Male</i>  | 10. COLOR OR RACE <i>W.</i> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i> | 12. DATE OF BIRTH <i>Sept 24, 1879</i>   |  | 13. AGE (in years last birthday) <i>73</i>                 |
| 14. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) <i>retired</i>                        |                             |  | 15. KIND OF BUSINESS OR INDUSTRY <i>U.S. POSTMAN</i>   |  | 16. BIRTHPLACE (State or foreign country) <i>Baltimore</i> |
| 17. FATHER'S NAME <i>Wm H.</i>  |                             |  | 18. MOTHER'S MAIDEN NAME <i>Sarah E. Switzer</i>   |  |  |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                             |  | 20. SOCIAL SECURITY NO.  |  |  |
| 21. 17. INFORMANT   |                             |  | 22. ADDRESS  |  |  |

|   |  |  |  |                                      |  |
|---|--|--|--|--------------------------------------|--|
| 23. 18. 162X  |  | 24. CAUSE OF DEATH   |  | 25. INTERVAL BETWEEN ONSET AND DEATH |  |
| 26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | 27. (A) <i>Carcinomatosis - primary</i><br>DUE TO <i>carcinoma of lung</i> |  |                                      |  |
| 28. ANTECEDENT CAUSES   |  | 29. (B)  |  |                                      |  |
| 30. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | 31. (C)  |  |                                      |  |
| 32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |                                      |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 33. 19A. DATE OF OPERATION <i>0</i>  |  | 34. 19B. MAJOR FINDINGS OF OPERATION   |  | 35. 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 36. 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 37. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 38. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 39. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 40. 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 41. 21F. HOW DID INJURY OCCUR?   |  |
| 42. I hereby certify that I attended the deceased from <i>June 13</i> , 19 <i>53</i> , to <i>July 20</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>July 20</i> , 19 <i>53</i> , and that death occurred at <i>10:10 P.M.</i> , from the causes and on the date stated above. |  |  |  |  |  |
| 43. 23A. SIGNATURE <i>Geo. J. Lin</i>  |  | 44. 23B. ADDRESS <i>General Hospital</i>   |  | 45. 23C. DATE SIGNED <i>July 20 '53</i>  |  |
| 46. 24B. DATE <i>7/23/53</i>   |  | 47. 24C. NAME OF CEMETERY OR CREMATORY <i>Baldwin Methodist</i>  |  | 48. 24D. LOCATION (City, town or county) (State) <i>A.C. Co. Md.</i>                 |  |
| 49. 25. FUNERAL DIRECTOR   |  | 50. ADDRESS  |  |  |  |

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Noted Dec 22/11

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "William H. Anderson" and "Baltimore" are faintly visible.]*



M-320

FJ 169794

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6643

BIRTH No. 53 6643

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Elizabeth Matthews</b>  |                                  |   | 2. DATE OF DEATH<br><b>7-17-1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>                 |  |   |
| D. STREET ADDRESS (If rural, give location)<br><b>810 North Gay Street</b>  |                                  |   | E. LENGTH OF STAY IN BALTIMORE<br><b>life</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>July 4, 1881</b>   | 9. AGE (In years last birthday)<br><b>72</b> | 10. UNDER 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| 13. FATHER'S NAME<br><b>Jesse Coleman</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Coleman</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  |   | 16. SOCIAL SECURITY NO.   |  |   |
| 17. INFORMANT<br><b>B.C.H. 4940 Eastern Ave. (record)</b>   |                                  |   | ADDRESS   |  |   |

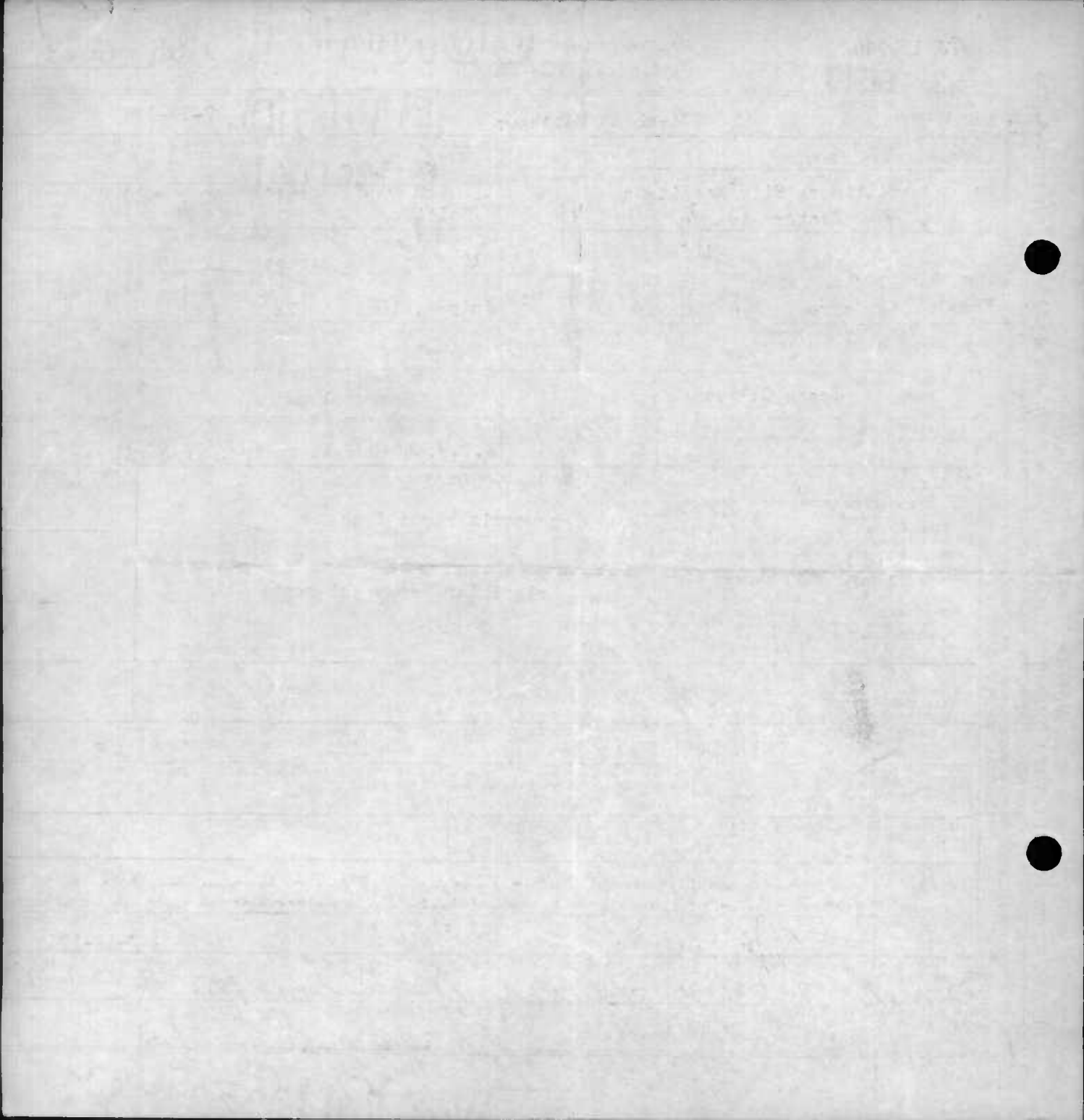
|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>446x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia right lung</b><br>DUE TO<br><b>Arteriolar Nephrosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(C)   |  |                                  |

|  |   |  |   |
|--|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  |   |
| 19A. DATE OF OPERATION<br><b>7</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

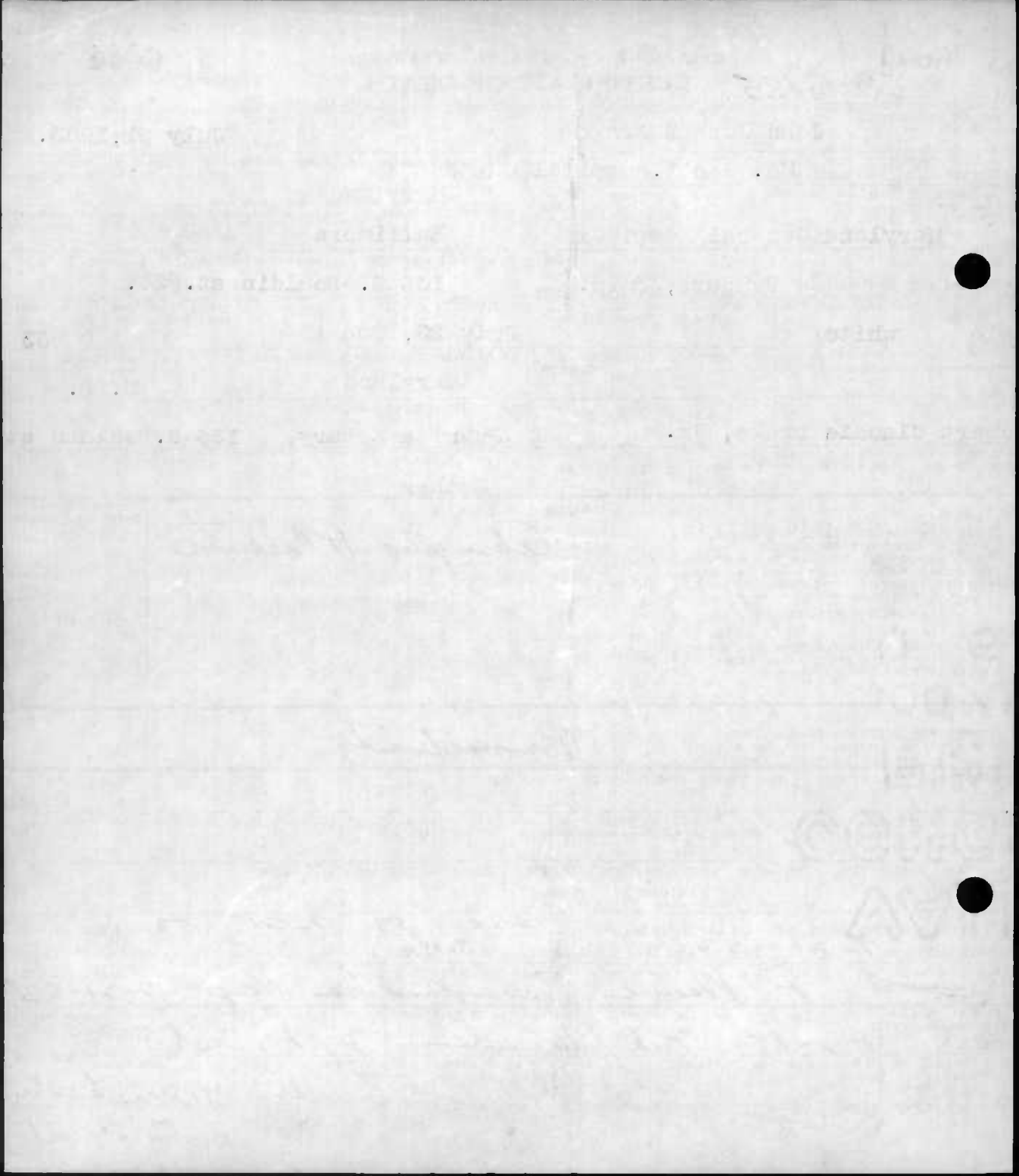
22. I hereby certify that I attended the deceased from **4 - 23 - 1953** to **7 - 17 - 1953**, that I last saw the deceased alive on **7 - 17 - 1953**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

|                                   |  |                                      |
|-----------------------------------|--|--------------------------------------|
| 23A. SIGNATURE<br><b>John Doe</b> | 23B. ADDRESS<br><b>4940 Eastern Avenue</b> | 23C. DATE SIGNED<br><b>7-17-1953</b> |
|-----------------------------------|--|--------------------------------------|

|  |   |  |  |
|--|---|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-23-53</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 21 1953</b>     | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Rayner Sanders</b>                      | ADDRESS<br><b>217 E. Preston St</b>                                  |



|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 53 6644  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 53 6644   |  |
| 53-16455   |  | CERTIFICATE OF DEATH  |  | Registered No.  |  |
| NAME OF DECEASED (Last, first, middle, or Print)   |  | John Joseph Drake   |  | 2. DATE OF DEATH July 21, 1953.   |  |
| PLACE OF DEATH: Baltimore City, Maryland Md. Gen'l. Hospital   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |  | A. STATE Maryland B. COUNTY   |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                              |  | Baltimore 26-10   |  |
| M. D. Maryland General Hospital  |  | D. STREET ADDRESS (If rural, give location)   |  | 136 S. Bouldin st. #24.   |  |
| Length of stay in Baltimore 9 hours, 33 min.   |  | Yrs. Mos. Days  |  |   |  |
| 5. SEX male  |  | 6. COLOR OR RACE white  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |  |
| 8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH July 20, 1953  |  |
| FATHER'S NAME Robert Claudie Drake, Jr.  |  | 14. MOTHER'S MAIDEN NAME Juanita Asbury, 136 S. Bouldin st  |  | 9. AGE (in years last birthday) 9 Under 1 Year Months: Days 33 Under 24 Hours Hours: Min. |  |
| 11. BIRTHPLACE (State or foreign country) Maryland   |  | 12. CITIZEN OF WHAT COUNTRY? U. S.  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT Mother   |  | ADDRESS   |  |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                         |  | CAUSE OF DEATH Abruptio Placenta  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| II. ANTECEDENT CAUSES  |  | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | Prematurity   |  |   |  |
| 9A. DATE OF OPERATION 0  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                  |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute)   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  | 21F. HOW DID INJURY OCCUR?  |  |
| 2. I hereby certify that I attended the deceased from 7-20, 1953, to 7-21, 1953, that I last saw the deceased alive on 7-21, 1953, and that death occurred at 5:45 A.M., from the causes and on the date stated above. |  | 3A. SIGNATURE A. P. Vicente M. D.   |  | 23B. ADDRESS Maryland Gen. Hosp   |  |
| 23C. DATE SIGNED 7-21-53   |  | 24B. DATE 7/24/53   |  | 24C. NAME OF CEMETERY OR CREMATORY Fork Lutheran Cem.                                     |  |
| 24D. LOCATION (City, town, or county) (State) Fork Md.   |  | 25. FUNERAL DIRECTOR  |  | ADDRESS   |  |
| Huntington, W. Va.   |  | John S. Connelly  |  | 418 Eastern Ave. Balt. 2, Md.   |  |



-263

53 6645

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6645

RTH NO.

NAME OF DECEASED  
(Type or Print)

Adelaide Eckhart

2. DATE  
OF  
DEATH

July 20, 1953

PLACE OF DEATH:

Baltimore City, Maryland 45201 Patton Rd

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Northampton Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 5255

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

20 W Chesapeake Ave Worsen

SEX

F

6. COLOR OR RACE

10

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov 31-1898

9. AGE (In years  
last birthday)

54

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

Dramatics

10B. KIND OF BUSINESS OR  
INDUSTRY

Department Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

Louis Eckhart

14. MOTHER'S MAIDEN NAME

Mary W. Worsen

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-03-8878

17. INFORMANT

Mrs. Loretta Shuler 20 W Chesapeake Ave Worsen

ADDRESS

18. 442X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage 3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive Cardio- 15 yrs  
Renal Vascular Disease

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from Oct 1947 to July 19, 1953 that I last saw the  
deceased alive on July 18, 1953, and that death occurred at 5:40 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D. 610 York Rd Worsen Md

VS. 150

6336C

Worsen Md

Dr. O'Connell



-600

53 6646

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6646  
Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print)

Maria A. Gray

2. DATE  
OF  
DEATH

7-19-53

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or  
OSPITAL OR location)  
STITUTION

2907 Parkwood Ave

Length of stay in Baltimore

SEX 7 6. COLOR OR RACE C 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W

A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Mr Latane

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

8-31-1872

9. AGE (In years  
last birthday)

80

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Essex Co. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Isabelle Harris

17. INFORMANT

ADDRESS

Caroline Ross - 2907 Parkwood

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Senility

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

Multiple decubiti

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20, 1953 to 7-19, 1953, that I last saw the  
deceased alive on 7-18, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

C.R. Campbell

M. O.

23B. ADDRESS

718 Dolphin St.

23C. DATE SIGNED

7-21-53

A. BURIAL, CREMA-  
N. REMOVAL (Specify)

24B. DATE

7-24-53

24C. NAME OF CEMETERY OR CREMATORY

Western Star Co

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Samuel W. Sullivan, Jr

1011 1/2 Arlington Ave

VS 150

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF DENVER

1011 J. Anderson  
Denver, CO

1-622

3 6647

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6647

Registered No.

|   |                  |   |                                  |
|---|------------------|---|----------------------------------|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)                                    |                  | 2. DATE OF DEATH  |                                  |
| CATHERINE MARSIGLIA   |                  | 7/20/53   |                                  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) |                  | A. STATE  |                                  |
| UNION MEMORIAL HOSP.  |                  | MARYLAND  |                                  |
| 6. LENGTH OF stay in Baltimore  |                  | B. COUNTY   |                                  |
| LIFE  |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |                                  |
| Yrs. Mos. Days  |                  | BALTIMORE-29 20-07  |                                  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |                  | D. STREET ADDRESS (If rural, give location)   |                                  |
| M   |                  | 8 MORLEY ST.  |                                  |
| 8. SEX  | 9. COLOR OR RACE | 10. DATE OF BIRTH   | 11. AGE (In years last birthday) |
| F   | W                | 2/19/02   | 51                               |
| 12. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)   |                  | 13. If Under 1 Year Months: Days  |                                  |
| HOUSE WIFE  |                  | 14. If Under 24 Hours Hours: Min.   |                                  |
| 15. KIND OF BUSINESS OR INDUSTRY  |                  | 16. BIRTHPLACE (State or foreign country)   |                                  |
| —   |                  | MARYLAND  |                                  |
| 17. FATHER'S NAME   |                  | 18. CITIZEN OF WHAT COUNTRY?  |                                  |
| GEORGE WROTEN   |                  | US  |                                  |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)           |                  | 20. SOCIAL SECURITY NO.   |                                  |
| NO  |                  | ?   |                                  |
| 21. 17. INFORMANT   |                  | 22. ADDRESS   |                                  |
| SAME  |                  |   |                                  |

|   |  |                        |  |                                  |  |
|---|--|------------------------|--|----------------------------------|--|
| 8. 592x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH         |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) ANTECEDENT CAUSES   |  | Myo cardial infarction |  |                                  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) Hypertension       |  |                                  |  |
|   |  | (C) Chronic nephritis  |  |                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                        |  |                                  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 9A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?  |  |

|   |  |                       |  |                                    |  |
|---|--|-----------------------|--|------------------------------------|--|
| 22. I hereby certify that I attended the deceased from 7/10/53, 19, to 7/20/53, 19, that I last saw the deceased alive on 7/20/53, 19, and that death occurred at 5:43 P. M., from the causes and on the date stated above. |  |                       |  |                                    |  |
| 23A. SIGNATURE  |  | 23B. ADDRESS          |  | 23C. DATE SIGNED                   |  |
| Henry S. Knock, Jr.   |  | Union Memorial Hosp.  |  | 7/20/53                            |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE             |  | 24C. NAME OF CEMETERY OR CREMATORY |  |
| Burial  |  | July 23-1953          |  | New Cathedral Cemetery             |  |
| 24D. LOCATION (City, town, or county) (State)   |  | 25. FUNERAL DIRECTOR  |  | ADDRESS                            |  |
| 4300 Old Frederick Rd B. Md   |  | Joseph Garase Inc.    |  | 712-14 E. North Ave                |  |
| RECEIVED BY AL REGISTRAR  |  | REGISTRAR'S SIGNATURE |  | 25. FUNERAL DIRECTOR ADDRESS       |  |
| JUL 22 1953   |  | Huntington Williams   |  |                                    |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

|  |  |
|--|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS                       |  |
| 2. SEX<br>Male   |  |
| 3. AGE<br>65   |  |
| 4. DATE OF DEATH<br>JAN 15 1915                              |  |
| 5. PLACE OF DEATH<br>New York City                           |  |
| 6. CAUSE OF DEATH<br>Heart Disease                           |  |
| 7. PLACE OF BIRTH<br>New York City                           |  |
| 8. OCCUPATION<br>Clerk                                       |  |
| 9. MARITAL STATUS<br>Married                                 |  |
| 10. SIGNATURE OF DECEASED<br>(None)                          |  |
| 11. SIGNATURE OF WITNESSES<br>(None)                         |  |
| 12. SIGNATURE OF DECEASED'S NEAREST RELATIVE<br>(None)       |  |
| 13. SIGNATURE OF DECEASED'S PHYSICIAN<br>(None)              |  |
| 14. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL<br>(None) |  |
| 15. SIGNATURE OF DECEASED'S CHURCH CLERK<br>(None)           |  |
| 16. SIGNATURE OF DECEASED'S MARRIAGE CLERK<br>(None)         |  |
| 17. SIGNATURE OF DECEASED'S BURIAL CLERK<br>(None)           |  |
| 18. SIGNATURE OF DECEASED'S FUNERAL HOME<br>(None)           |  |
| 19. SIGNATURE OF DECEASED'S CEMETERY<br>(None)               |  |
| 20. SIGNATURE OF DECEASED'S INTERMENT<br>(None)              |  |

-400

53 6648

TH No.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6648

NAME OF DECEASED  
(Last name or Print)

ROBERT L. COLE

2. DATE  
OF  
DEATH

July 19, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

SPITAL OR

TITUTION

623 Pitcher St

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 31, 1888

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.USUAL OCCUPATION (Give kind of  
one during most of work log life, even if retired)

Chauffeur

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

Joseph Cole

14. MOTHER'S MAIDEN NAME

Martha E. Brown

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Alice Smith

ADDRESS 1106

Druid Hill Ave.

B. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CARDIO VASCULAR DISEASE

1 YR.

DUE TO

## ANTECEDENT CAUSES

(B) .....

DUE TO

(C) .....

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 9, 1953, to July 19, 1953, that I last saw the  
deceased alive on July 11, 1953, and that death occurred at 7 A-m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7-22-53

Mt. Auburn Cem

Baltimore.

Md.

RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 578a

1227053

H.ington Williams, M.D.

Dr. Frances W. Hausley, B.S.

53 60

1910-1911

1910-1911

1910-1911

1910-1911

1910-1911

1910-1911

1910-1911

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1910-1911

1910-1911

1910-1911

1910-1911

1910-1911



400

|   |  |  |
|---|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | Registered No. <b>53 6649</b>  |
| NAME OF DECEASED (Last, first, middle name or Print)<br><b>Levin Jolly</b>  |  | 2. DATE OF DEATH<br><b>July 20, 1953</b>                                 |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland 1907 Druid Hill</b>  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>None</b>   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 14-03</b>                                 |  |
| Length of stay in Baltimore<br><b>Life</b>  | D. STREET ADDRESS (If rural, give location)<br><b>1907 Druid Hill Ave</b>  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>C</b>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>              |
| 8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>Cook</b>   | 10A. KIND OF BUSINESS OR INDUSTRY<br><b>HOTEL</b>  | 8. DATE OF BIRTH<br><b>1874</b>  |
| FATHER'S NAME<br><b>William S. Jolly</b>  |  | 9. AGE (In years last birthday)<br><b>79</b>                             |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                             |
| 14. MOTHER'S MAIDEN NAME<br><b>Roxanna Wilson</b>   |  | 17. INFORMANT<br><b>Birdie Jolly Weaver</b>                              |
| 16. SOCIAL SECURITY NO.   |  | ADDRESS<br><b>1907 Druid Hill</b>  |
| B. <b>443X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Congestive Heart Failure</b><br>DUE TO<br><b>A.H.C.V.D</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>None</b> |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>None</b>   |  |  |
| 9A. DATE OF OPERATION<br><b>None</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>May 10 1952</b> , to <b>July 20 1953</b> , that I last saw the deceased alive on <b>July 20, 1953</b> and that death occurred at <b>2 P. m.</b> , from the causes and on the date stated above.   |  |  |
| 23A. SIGNATURE<br><b>George McDonald</b>  | 23B. ADDRESS<br><b>844 N. Carey St. Balt. Md</b>   | 23C. DATE SIGNED<br><b>7/21/53</b>                                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>July 23, 53</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>West Auburn</b>                 |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto</b>   | 25. FUNERAL DIRECTOR<br><b>James A. Hayes</b>  |  |
| RECEIVED BY<br><b>Huntington Williams, MD</b>   |  |  |
| ADDRESS<br><b>638 N. Belvoir</b>  |  |  |



-320

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6650

TH No.

NAME OF DECEASED  
(Last, first, middle, or Print)PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
TITUTION

Length of stay in Baltimore

SEX

7

6. COLOR OR RACE

1. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

FATHER'S NAME

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

11

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/20, 1953 to 7/21, 1953 that I last saw the  
deceased alive on 7/20, 1953 and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



562  
3 6651BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6651  
Registered No.

|  |                              |   |                                       |
|--|------------------------------|---|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print)<br><b>JOSEPH SUMMERS</b>   |                              | 2. DATE OF DEATH<br><b>JULY 21, 53</b>  |                                       |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>BALTO</b> |                                       |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MERCY HOSP INC.</b>  |                              | C. CITY OR TOWN<br><b>BALTO.</b><br>(If outside corporate limits, write RURAL and give township)                                      |                                       |
| 6. Length of stay in Baltimore<br><b>150X</b>  |                              | D. STREET ADDRESS (If rural, give location)<br><b>2619 E. HOFFMAN ST</b>  |                                       |
| 7. SEX<br><b>M</b>   | 8. COLOR OR RACE<br><b>W</b> | 9. SINGLE <input checked="" type="checkbox"/> MARRIED<br>WIDOWED, DIVORCED (Specify)  | 10. DATE OF BIRTH<br><b>1-17-1905</b> |
| 11. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)<br><b>UNEMPLOYED</b>  |                              | 12. AGE (In years last birthday)<br><b>48</b>   |                                       |
| 13. FATHER'S NAME<br><b>ROBT. SUMMERS</b>  |                              | 14. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>?</b>  |                              | 16. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                       |
| 17. SOCIAL SECURITY NO.  |                              | 18. MOTHER'S MAIDEN NAME<br><b>JULIA HELSINKI</b>   |                                       |
| 19. INFORMANT<br><b>WIFE</b>   |                              | 20. ADDRESS<br><b>ABOVE</b>   |                                       |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARCINOMA OF ESOPHAGUS</b>                         |                              | 22. INTERVAL BETWEEN ONSET AND DEATH  |                                       |
| 23. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                              | 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                   |                                       |
| 25. DATE OF OPERATION<br><b>7</b>  |                              | 26. MAJOR FINDINGS OF OPERATION   |                                       |
| 27. DATE OF AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |                              | 28. DATE OF OPERATION<br><b>7</b>   |                                       |
| 29. DATE OF OPERATION<br><b>7</b>  |                              | 30. MAJOR FINDINGS OF OPERATION   |                                       |
| 31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                              | 32. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                       |
| 33. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                              | 34. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                       |
| 35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 36. HOW DID INJURY OCCUR?   |                                       |
| 37. I hereby certify that I attended the deceased from <b>JULY 12, 1953</b> to <b>JULY 21, 1953</b> that I last saw the deceased alive on <b>JULY 21, 1953</b> , and that death occurred at <b>1:45 P.m.</b> , from the causes and on the date stated above. |                              |   |                                       |
| 38. SIGNATURE<br><b>Thomas Goutney, M.D.</b>   |                              | 39. ADDRESS<br><b>MERCY HOSPITAL</b>  |                                       |
| 40. DATE SIGNED<br><b>7/21/53</b>  |                              | 41. DATE SIGNED   |                                       |
| 42. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial July 23-1953</b>   |                              | 43. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>   |                                       |
| 44. LOCATION (City, town, or county) (State)<br><b>German Hill Rd. Md.</b>   |                              | 45. FUNERAL DIRECTOR<br><b>John J. Deuda Inc.</b>   |                                       |
| 46. ADDRESS<br><b>2829 Ches St.</b>  |                              | 47. ADDRESS   |                                       |
| 48. VS 150   |                              |   |                                       |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6652****53 6652**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**JOSEPH HEINLEIN**2. DATE  
OF DEATH **July 20, 1953**3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE **Maryland** B. COUNTYB. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION**St. Joseph's Hospital**C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
**Baltimore** township)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

**Little Sisters of Poor-Valley St.**

5. SEX

**Male**

6. COLOR OR RACE

**White**7. ~~SINGLE, MARRIED,~~  
WIDOWED, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH

**March 21, 1874**9. AGE (In years  
last birthday) **79**If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**Laborer**10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Germany**12. CITIZEN OF  
WHAT COUNTRY?  
**U. S.**

13. FATHER'S NAME

**John Heinlein**

14. MOTHER'S MAIDEN NAME

**Margaret ?**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**Little Sisters of the Poor**18. **E 900.7**

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **Fracture of skull**

DUE TO

## ANTECEDENT CAUSES

(B) **Subarachnoid hemorrhage**

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(C) **Laceration of right parieto-occipital  
region of brain**

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)  
**home**21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?**Little Sister of Poor-Valley St.**

21D. TIME (Month) (Day) (Year) (Hour)

**July 20, 1953****5:00 P. M.**

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Fell down steps**22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph G. Jachimczyk**

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

**July 21, 1953**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
**Burial**

24B. DATE

**July 24/53**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Redeemer**

24D. LOCATION (City, town, or county)

**Baltimore**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

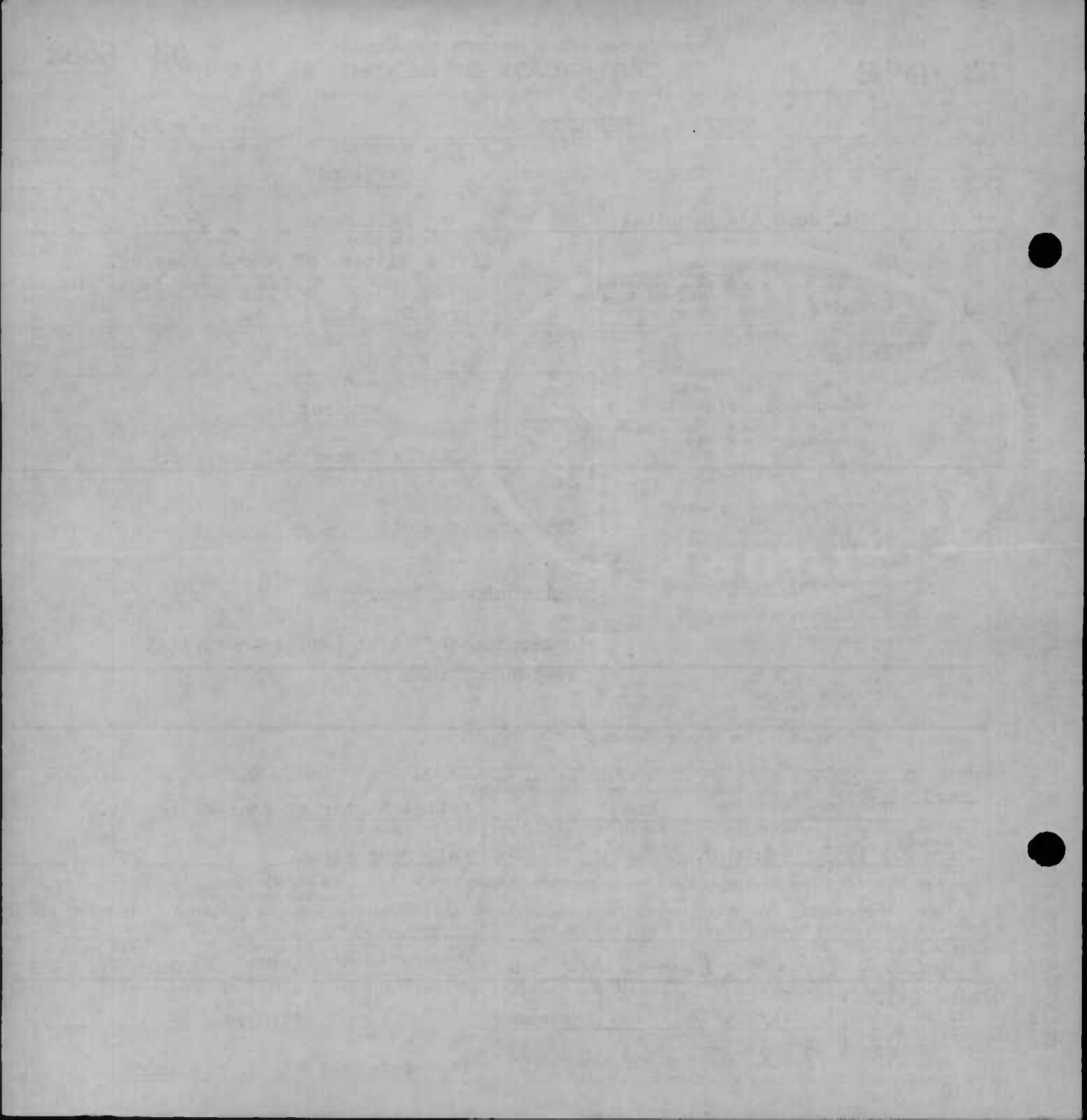
25. FUNERAL DIRECTOR

ADDRESS

**Rita Wiedefeld 900 E. Biddle St**

VS 151

**N 803.2**



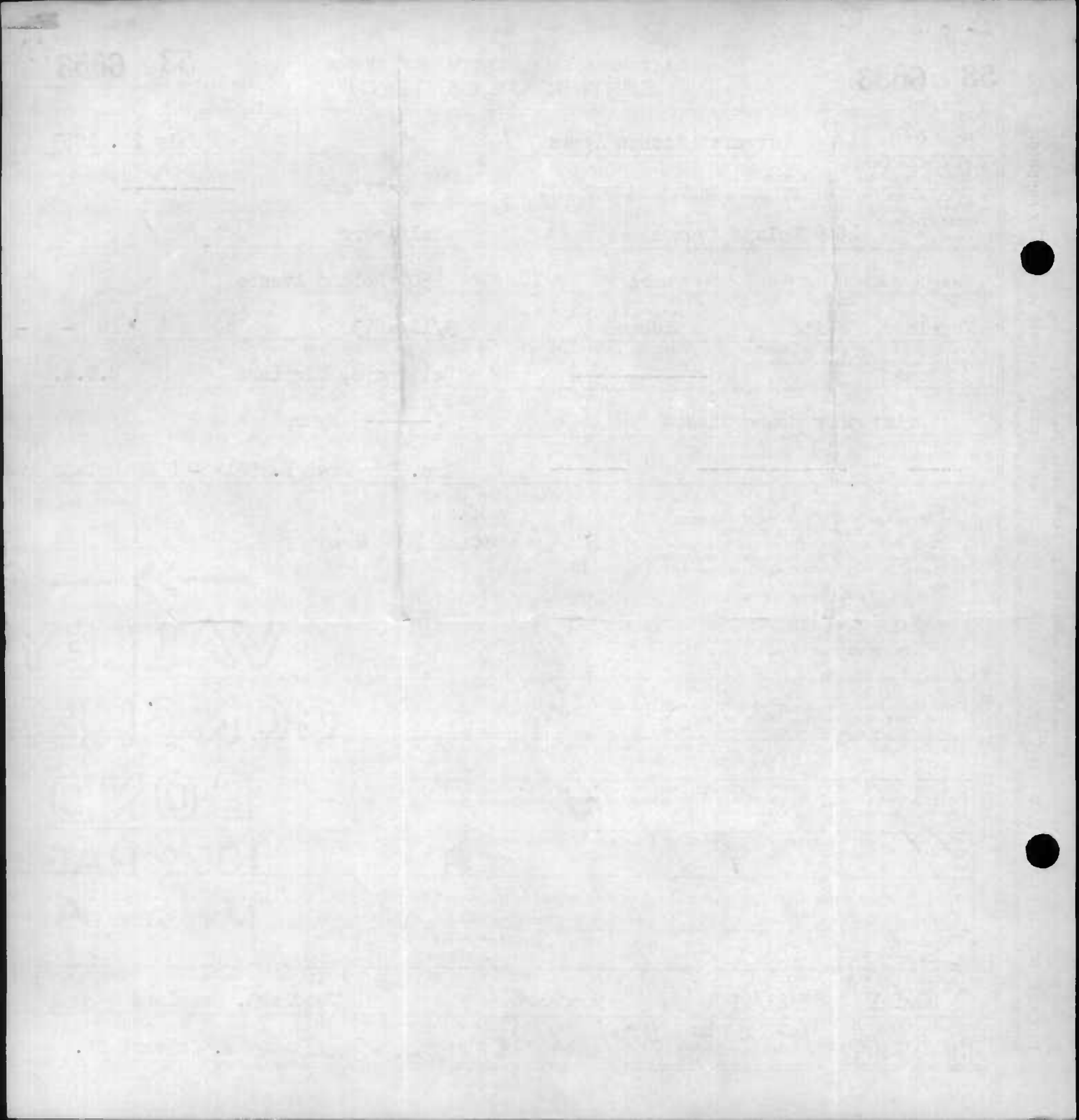
A-620

53 6653

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6653

|  |                  |  |                  |  |   |
|--|------------------|--|------------------|--|---|
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE OF DEATH   |   |
|  |                  | Margaret Sisson Ayres  |                  | July 21. 1953  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                  |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION  |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |                  |  |   |
| 4509 Roland Avenue   |                  | Baltimore 27-14  |                  |  |   |
| c. Length of stay in Baltimore   |                  | D. STREET ADDRESS (If rural, give location)  |                  |  |   |
| 80 years   |                  | 4509 Roland Avenue   |                  |  |   |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| Female   | White            | Widowed  | 3/11/1873        | 80   | 4 10 - -  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |   |
| None   |                  |  |                  | Baltimore, Maryland  |   |
| 13. FATHER'S NAME  |                  | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| Christopher Roane Sisson   |                  | ----- Myers  |                  | U.S.A.   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |   |
|  |                  |  |                  | Mrs. Margaret L. Cole - 4509 Roland Ave                                  |   |
| 18. 446X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                           |                  | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| (A) Chronic Nephritis  |                  | DUE TO   |                  | 5 yrs  |   |
| ANTECEDENT CAUSES  |                  | (B) arteriosclerosis   |                  | 10 + yrs   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                  | (C)  |                  |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |  |                  |  |   |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |   |
|  |                  |  |                  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
|  |                  |  |                  |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                  | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |                  | 21F. HOW DID INJURY OCCUR?   |   |
|  |                  |  |                  |  |   |
| 22. I hereby certify that I attended the deceased from 10/13/42, 19__, to 7/21/53, 19__, that I last saw the deceased alive on 7/20/53, 19__, and that death occurred at 5:34 a.m. from the causes and on the date stated above. |                  |  |                  |  |   |
| 23A. SIGNATURE   |                  | 23B. ADDRESS   |                  | 23C. DATE SIGNED   |   |
| Francis W. H. H. H.  |                  | 100 W. University Pkwy   |                  | 7/22/53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                  | 24B. DATE  |                  | 24C. NAME OF CEMETERY OR CREMATORY                                       |   |
| Burial   |                  | 7/23/53  |                  | Woodlawn   |   |
| 24D. LOCATION (City, town, or county) (State)  |                  | 25. FUNERAL DIRECTOR'S ADDRESS   |                  |  |   |
| Woodlawn, Maryland   |                  | Huntington Williams, M.D. H. M. M. Son   |                  | 805 N. Calvert St.   |   |
| DATE RECEIVED BY LOCAL REGISTRAR   |                  | REGISTRAR'S SIGNATURE  |                  |  |   |
| JUL 22 1953  |                  | Huntington Williams, M.D.  |                  |  |   |



1-245

MUSCOLINO

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6654

IRTH NO.

NAME OF DECEASED

HARRIETT MUSCOLINO

2. DATE  
OF  
DEATH

July 21, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

FRANKLIN SQUARE HOSPITAL

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

Balto. Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

36 S. Carey St. 19-03

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

SEX 6. COLOR OR RACE

F W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-18-1879

9. AGE (In years last birthday)

73

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

FATHER'S NAME

James Craft

14. MOTHER'S MAIDEN NAME

CALLAHAN

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

no or (unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CARMELLO MUSCOLINO 36 S. Carey St

18. 443X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardio. vascular disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

6 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1953, to July 21, 1953, that I last saw the deceased alive on July 21, 1953, and that death occurred at 10:45 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Lorraine Park Cem

Franklin Square Hosp.

Jul 21 1953

A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

7-23-53

LORRAINE PARK Cem

Woodlawn BALTO. Md

TE RECEIVED BY CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 22 1953

Huntington Machine Works, M.D. THOMAS J. Kealey Inc. 1600 Hollins St

VS 150

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1904

|                                   |  |                             |  |                           |  |
|-----------------------------------|--|-----------------------------|--|---------------------------|--|
| 1. Name of deceased               |  | 2. Sex                      |  | 3. Race                   |  |
| 4. Date of death                  |  | 5. Time of death            |  | 6. Place of death         |  |
| 7. Cause of death                 |  | 8. Manner of death          |  | 9. Signature of physician |  |
| 10. Signature of registrar        |  | 11. Signature of informant  |  | 12. Signature of witness  |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker |  | 15. Signature of cemetery |  |
| 16. Signature of health officer   |  | 17. Signature of coroner    |  | 18. Signature of jury     |  |
| 19. Signature of jury             |  | 20. Signature of jury       |  | 21. Signature of jury     |  |
| 22. Signature of jury             |  | 23. Signature of jury       |  | 24. Signature of jury     |  |
| 25. Signature of jury             |  | 26. Signature of jury       |  | 27. Signature of jury     |  |
| 28. Signature of jury             |  | 29. Signature of jury       |  | 30. Signature of jury     |  |
| 31. Signature of jury             |  | 32. Signature of jury       |  | 33. Signature of jury     |  |
| 34. Signature of jury             |  | 35. Signature of jury       |  | 36. Signature of jury     |  |
| 37. Signature of jury             |  | 38. Signature of jury       |  | 39. Signature of jury     |  |
| 40. Signature of jury             |  | 41. Signature of jury       |  | 42. Signature of jury     |  |
| 43. Signature of jury             |  | 44. Signature of jury       |  | 45. Signature of jury     |  |
| 46. Signature of jury             |  | 47. Signature of jury       |  | 48. Signature of jury     |  |
| 49. Signature of jury             |  | 50. Signature of jury       |  | 51. Signature of jury     |  |
| 52. Signature of jury             |  | 53. Signature of jury       |  | 54. Signature of jury     |  |
| 55. Signature of jury             |  | 56. Signature of jury       |  | 57. Signature of jury     |  |
| 58. Signature of jury             |  | 59. Signature of jury       |  | 60. Signature of jury     |  |
| 61. Signature of jury             |  | 62. Signature of jury       |  | 63. Signature of jury     |  |
| 64. Signature of jury             |  | 65. Signature of jury       |  | 66. Signature of jury     |  |
| 67. Signature of jury             |  | 68. Signature of jury       |  | 69. Signature of jury     |  |
| 70. Signature of jury             |  | 71. Signature of jury       |  | 72. Signature of jury     |  |
| 73. Signature of jury             |  | 74. Signature of jury       |  | 75. Signature of jury     |  |
| 76. Signature of jury             |  | 77. Signature of jury       |  | 78. Signature of jury     |  |
| 79. Signature of jury             |  | 80. Signature of jury       |  | 81. Signature of jury     |  |
| 82. Signature of jury             |  | 83. Signature of jury       |  | 84. Signature of jury     |  |
| 85. Signature of jury             |  | 86. Signature of jury       |  | 87. Signature of jury     |  |
| 88. Signature of jury             |  | 89. Signature of jury       |  | 90. Signature of jury     |  |
| 91. Signature of jury             |  | 92. Signature of jury       |  | 93. Signature of jury     |  |
| 94. Signature of jury             |  | 95. Signature of jury       |  | 96. Signature of jury     |  |
| 97. Signature of jury             |  | 98. Signature of jury       |  | 99. Signature of jury     |  |
| 100. Signature of jury            |  | 101. Signature of jury      |  | 102. Signature of jury    |  |



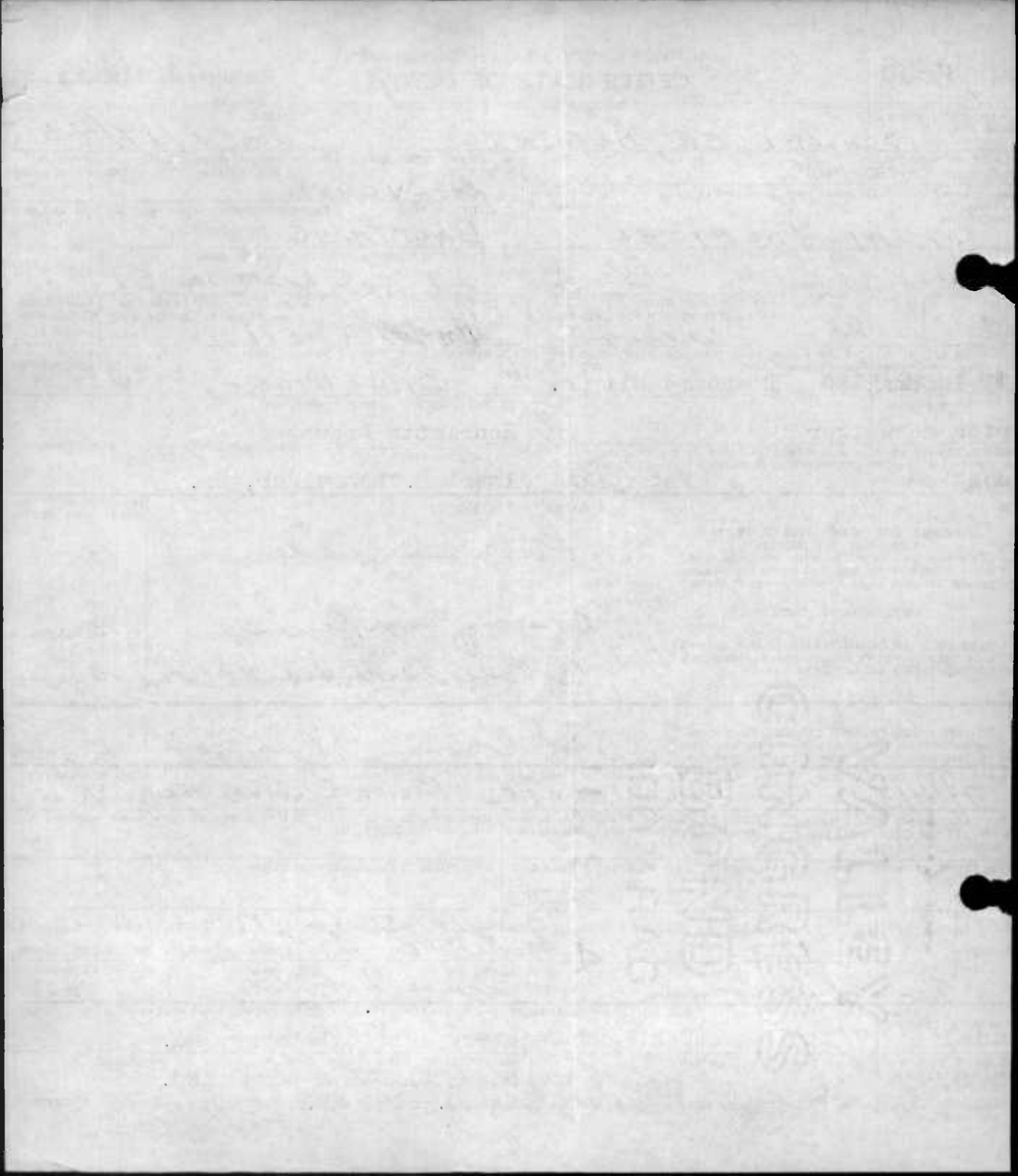
5-260

3 6655

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6655

|   |                  |  |                                  |
|---|------------------|--|----------------------------------|
| NAME OF DECEASED<br>(Last, first, and middle name or Print)   |                  | 2. DATE OF DEATH   |                                  |
| SCHWEIGER, ALBERT   |                  | 7/19/53  |                                  |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                                  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  |                  | A. STATE   |                                  |
| SINAI HOSPITAL  |                  | MARYLAND   |                                  |
| of stay in Baltimore  |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)             |                                  |
| Life  |                  | BALTIMORE 26-10  |                                  |
| Yrs. Mos. Days  |                  | D. STREET ADDRESS (If rural, give location)  |                                  |
|   |                  | 327 S. CLINTON ST #24  |                                  |
| 5. SEX  | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH                 |
| M   | W                | Widower  | July 4, 1882                     |
| 9. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)   |                  | 9. AGE (In years last birthday)  |                                  |
| PE-INSULATING   |                  | 71   |                                  |
| 10a. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)  |                                  |
| Standard Oil Co.  |                  | BALTIMORE  |                                  |
| FATHER'S NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| rton Schweiger  |                  | US.  |                                  |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  |                  | 14. MOTHER'S MAIDEN NAME   |                                  |
| no  |                  | Henrietta Braun  |                                  |
| 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT  |                                  |
| 215-05-8843   |                  | ADDRESS  |                                  |
| Albert L. Schweiger, Jr.  |                  |  |                                  |
| 18. CAUSE OF DEATH  |                  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                |                  |  |                                  |
| (A) Pulmonary edema   |                  |  | 10 min                           |
| DUE TO  |                  |  |                                  |
| (B) Coronary insufficiency  |                  |  | 10 yrs                           |
| DUE TO  |                  |  |                                  |
| (C) Arteriosclerotic heart disease  |                  |  | 10 yrs                           |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |  |                                  |
| Old Coronary Thrombosis   |                  |  | 10 yrs                           |
| 19A. DATE OF OPERATION  |                  | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 7/14/53   |                  | INCARCERATED RIGHT INGUINAL HERNIA   |                                  |
| 20. AUTOPSY?  |                  |  |                                  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                  |
|   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                 |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED   |                                  |
|   |                  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |                                  |
| 21F. HOW DID INJURY OCCUR?  |                  |  |                                  |
| 22. I hereby certify that I attended the deceased from July 14, 1953 to July 19, 1953, that I last saw the deceased alive on July 19, 1953, and that death occurred at 2:50 P.m., from the causes and on the date stated above. |                  |  |                                  |
| 23A. SIGNATURE  |                  | 23B. ADDRESS   |                                  |
| Harold Susoman  |                  | Sinai Hospital   |                                  |
| M. D.   |                  | 23C. DATE SIGNED   |                                  |
|   |                  | 7/19/53  |                                  |
| 24B. DATE   |                  | 24C. NAME OF CEMETERY OR CREMATORY   |                                  |
| 7/22/53   |                  | Oak Lawn Cemetery  |                                  |
| 24D. LOCATION (City, town, or county)   |                  | (State)  |                                  |
| Baltimore, Md.  |                  |  |                                  |
| 25. FUNERAL DIRECTOR  |                  | ADDRESS  |                                  |
| HENRY SANDER & SONS INC.  |                  |  |                                  |
| BALTO., 13, MD.   |                  |  |                                  |
| 620 22  |                  |  |                                  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6656

53 6656

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DOROTHY Estella PATTERSON

2. DATE OF DEATH July 19, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex - Harewood Park

D. STREET ADDRESS (If rural, give location)

Route 14, Box 384

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH

May 31, 1937

9. AGE (In years last birthday) 16

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Girl

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Patterson

14. MOTHER'S MAIDEN NAME

Dorothy Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO. none

17. INFORMANT Harewood Park Md. ADDRESS Mr. Louis Patterson

18. E929.8

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Submersion

## ANTECEDENT CAUSES

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) river

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Gunpowder River

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 7-19-53 6:25 P.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

aquaplane pulled under when caught in rope of

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*J. R. Sander*

M.D.

23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....

23C. DATE SIGNED 7-20-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

7/23/53

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington*

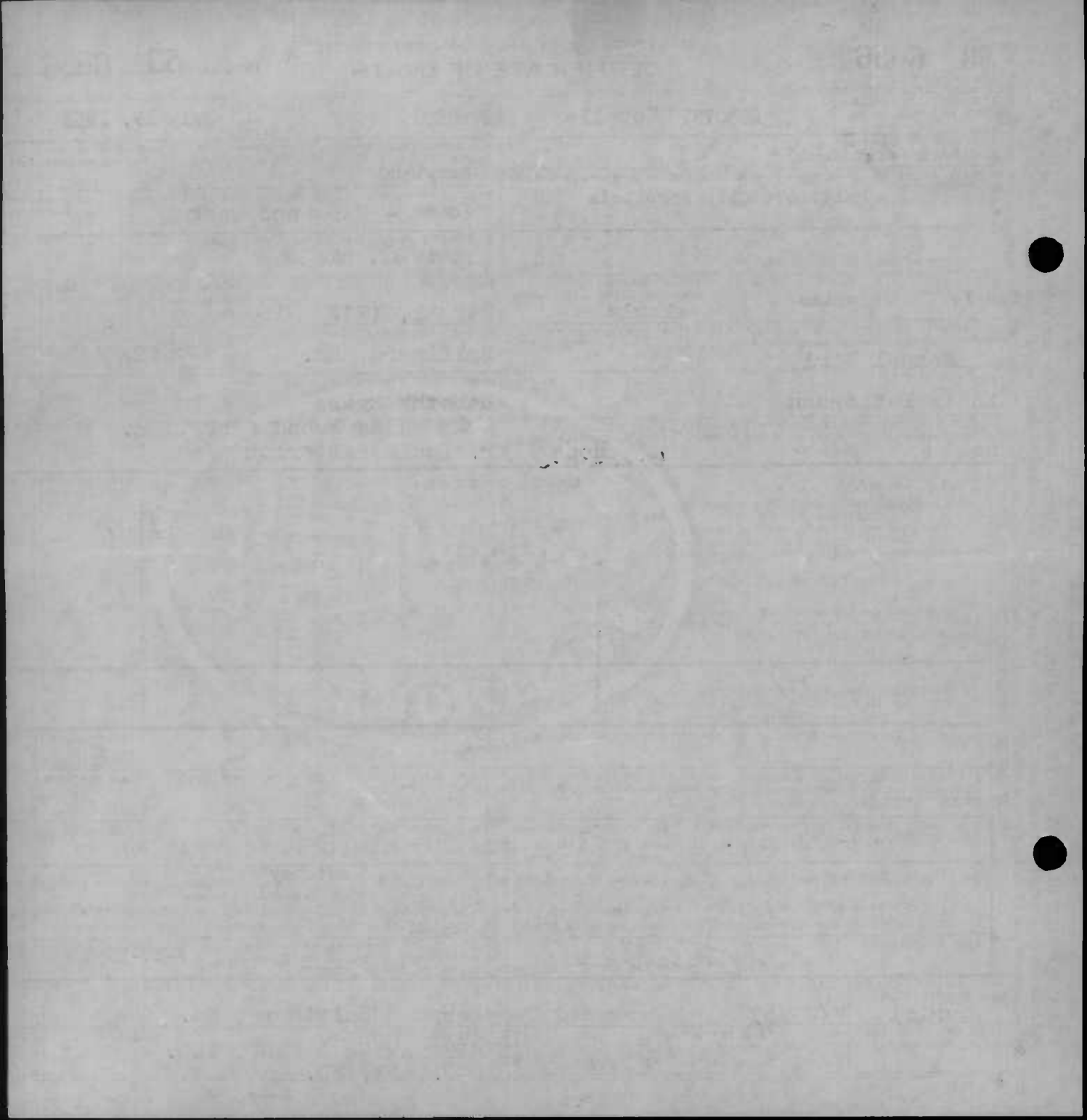
25. FUNERAL DIRECTOR

HENRY SANDER &amp; SONS, INC.

ADDRESS

BALTO., 13, MD.

*Henry P. Sander*



SOWERS

53 6657 53 6657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 53 6657 53 6657

|   |                            |   |   |
|---|----------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Baby Boy Sowers</i>   |                            | 2. DATE OF DEATH <i>7-21-1953</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>Howard</i> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>   |                            | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Elkridge</i> 27                                  |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                            | D. STREET ADDRESS (If rural, give location)<br><i>6300</i>  |   |
| 5. SEX <i>M.</i>  | 6. COLOR OR RACE <i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>   | 8. DATE OF BIRTH <i>7-21-1953</i>                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>   | 9. AGE (In years last birthday) <i>45 minutes</i> |
| 13. FATHER'S NAME <i>Harry Sowers</i>   |                            | 11. BIRTHPLACE (State or foreign country) <i>Balto md</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>   |                            | 12. CITIZEN OF WHAT COUNTRY? <i>md</i>  |   |
| 16. SOCIAL SECURITY NO. <i>None</i>   |                            | 14. MOTHER'S MAIDEN NAME <i>Viola Sowers</i>  |   |
| 17. INFORMANT <i>Harry Sowers, Elkridge md</i>  |                            | ADDRESS   |   |
| 18. 776x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Pneumonia</i>                                       |                            |   |   |
| DUE TO  |                            |   |   |
| ANTECEDENT CAUSES   |                            |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO  |                            |   |   |
| (C)   |                            |   |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                            |   |   |
| 19A. DATE OF OPERATION <i>0</i>   |                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                            | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                            | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |   |
| 21F. HOW DID INJURY OCCUR?  |                            |   |   |
| 22. I hereby certify that I attended the deceased from <i>July 21</i> 19 <i>53</i> to <i>July 21</i> 19 <i>53</i> that I last saw the deceased alive on <i>July 21</i> 19 <i>53</i> and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above. |                            |   |   |
| 23A. SIGNATURE <i>A. Deulin</i> M. D.   |                            | 23B. ADDRESS <i>St. Agnes Hospital</i>  |   |
| 23C. DATE SIGNED <i>7/21/53</i>   |                            |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                            | 24B. DATE <i>7/22/53</i>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge</i>   |                            | 24D. LOCATION (City, town, or county) (State) <i>Elkridge md</i>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 22 1953</i>   |                            | 25. FUNERAL DIRECTOR <i>Huntington Williams, 4000 E. City</i> ADDRESS <i>md</i>   |   |

VS 150

8032



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

520  
53-6658

MELBROU E JONES  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53-6658

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Melbourne Jones</u>  |                                    | 2. DATE OF DEATH <u>July 21, 1953</u>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u><br>B. COUNTY <u>SCHWABET</u> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>JOHNS HOPKINS HOSPITAL</u>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u>  |  |
| c. Length of stay in Baltimore   |                                    | D. STREET ADDRESS (If rural, give location)<br><u>Box 35</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>   | 8. DATE OF BIRTH<br><u>12-28-12</u>          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Welder</u>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Welder</u>  | 9. AGE (In years last birthday)<br><u>40</u> |
| 13. FATHER'S NAME<br><u>Lemuel Jones</u>   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Jones</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                    | 16. SOCIAL SECURITY NO.<br><u>219-05-3178</u>   |  |
| 17. INFORMANT<br><u>JOHNS HOPKINS HOSPITAL</u>   |                                    | ADDRESS <input checked="" type="checkbox"/>   |  |
| 18. <u>002X</u> CAUSE OF DEATH   |                                    |   | INTERVAL BETWEEN ONSET AND DEATH             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Cor Pulmonale</u>   |                                    |   | <u>? 1 year</u>                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Chronic Pulmonary Tuberculosis</u>  |                                    |   | <u>? 7 yrs</u>                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                    |   |  |
| 19A. DATE OF OPERATION <u>0</u>  |                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                    | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                                    | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>7-17</u> , 19 <u>53</u> , to <u>7-21</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>53</u> , and that death occurred at <u>10:20</u> P.m., from the causes and on the date stated above. |                                    |   |  |
| 23A. SIGNATURE<br><u>P. D. McIntyre</u>  |                                    | 23B. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |  |
| 23C. DATE SIGNED<br><u>7-22-53</u>   |                                    |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                    | 24B. DATE<br><u>July 26, 1953</u>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><u>Dames Quarter</u>   |                                    | 24D. LOCATION (City, town, or county) (State)<br><u>Dames Quarter, Md.</u>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUL 22 1953</u>   |                                    | REGISTRAR'S SIGNATURE<br><u>Huntington Williams, M.D.</u>   |  |
| 25. FUNERAL DIRECTOR<br><u>Princess Anne, Md.</u>  |                                    | ADDRESS<br><u>910 12</u>  |  |

CERTIFICATE OF DEATH

|   |  |
|---|--|
| <p>1. Name of deceased: <i>John Doe</i></p>           |  |
| <p>2. Sex: <i>Male</i></p>                            |  |
| <p>3. Age: <i>45</i></p>                              |  |
| <p>4. Date of death: <i>Jan 15 1920</i></p>           |  |
| <p>5. Place of death: <i>Home</i></p>                 |  |
| <p>6. Cause of death: <i>Heart Disease</i></p>        |  |
| <p>7. Signature of physician: <i>Dr. J. Smith</i></p> |  |
| <p>8. Signature of registrar: <i>John Doe</i></p>     |  |
| <p>9. Signature of witness: <i>John Doe</i></p>       |  |
| <p>10. Signature of witness: <i>John Doe</i></p>      |  |
| <p>11. Signature of witness: <i>John Doe</i></p>      |  |
| <p>12. Signature of witness: <i>John Doe</i></p>      |  |
| <p>13. Signature of witness: <i>John Doe</i></p>      |  |
| <p>14. Signature of witness: <i>John Doe</i></p>      |  |
| <p>15. Signature of witness: <i>John Doe</i></p>      |  |
| <p>16. Signature of witness: <i>John Doe</i></p>      |  |
| <p>17. Signature of witness: <i>John Doe</i></p>      |  |
| <p>18. Signature of witness: <i>John Doe</i></p>      |  |
| <p>19. Signature of witness: <i>John Doe</i></p>      |  |
| <p>20. Signature of witness: <i>John Doe</i></p>      |  |
| <p>21. Signature of witness: <i>John Doe</i></p>      |  |
| <p>22. Signature of witness: <i>John Doe</i></p>      |  |
| <p>23. Signature of witness: <i>John Doe</i></p>      |  |
| <p>24. Signature of witness: <i>John Doe</i></p>      |  |
| <p>25. Signature of witness: <i>John Doe</i></p>      |  |
| <p>26. Signature of witness: <i>John Doe</i></p>      |  |
| <p>27. Signature of witness: <i>John Doe</i></p>      |  |
| <p>28. Signature of witness: <i>John Doe</i></p>      |  |
| <p>29. Signature of witness: <i>John Doe</i></p>      |  |
| <p>30. Signature of witness: <i>John Doe</i></p>      |  |
| <p>31. Signature of witness: <i>John Doe</i></p>      |  |
| <p>32. Signature of witness: <i>John Doe</i></p>      |  |
| <p>33. Signature of witness: <i>John Doe</i></p>      |  |
| <p>34. Signature of witness: <i>John Doe</i></p>      |  |
| <p>35. Signature of witness: <i>John Doe</i></p>      |  |
| <p>36. Signature of witness: <i>John Doe</i></p>      |  |
| <p>37. Signature of witness: <i>John Doe</i></p>      |  |
| <p>38. Signature of witness: <i>John Doe</i></p>      |  |
| <p>39. Signature of witness: <i>John Doe</i></p>      |  |
| <p>40. Signature of witness: <i>John Doe</i></p>      |  |
| <p>41. Signature of witness: <i>John Doe</i></p>      |  |
| <p>42. Signature of witness: <i>John Doe</i></p>      |  |
| <p>43. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>45. Signature of witness: <i>John Doe</i></p>      |  |
| <p>46. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>50. Signature of witness: <i>John Doe</i></p>      |  |
| <p>51. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>71. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>78. Signature of witness: <i>John Doe</i></p>      |  |
| <p>79. Signature of witness: <i>John Doe</i></p>      |  |
| <p>80. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>82. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>87. Signature of witness: <i>John Doe</i></p>      |  |
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| <p>89. Signature of witness: <i>John Doe</i></p>      |  |
| <p>90. Signature of witness: <i>John Doe</i></p>      |  |
| <p>91. Signature of witness: <i>John Doe</i></p>      |  |
| <p>92. Signature of witness: <i>John Doe</i></p>      |  |
| <p>93. Signature of witness: <i>John Doe</i></p>      |  |
| <p>94. Signature of witness: <i>John Doe</i></p>      |  |
| <p>95. Signature of witness: <i>John Doe</i></p>      |  |
| <p>96. Signature of witness: <i>John Doe</i></p>      |  |
| <p>97. Signature of witness: <i>John Doe</i></p>      |  |
| <p>98. Signature of witness: <i>John Doe</i></p>      |  |
| <p>99. Signature of witness: <i>John Doe</i></p>      |  |
| <p>100. Signature of witness: <i>John Doe</i></p>     |  |

543

6659

# HAMILTON

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

 Registered No. **53 6659**

TH NO.

NAME OF DECEASED  
(Name or Print)

Margaret Hamilton

2. DATE  
OF  
DEATH19 July 1953  
9-2a-8m.

PLACE OF DEATH:

Baltimore City, Maryland 1200 Valley St

FULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
TITUTION

Little Sisters of the Poor

Length of stay in Baltimore

6 yrs

Yrs.  
Mos.  
Days

SEX

female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Charles Hamilton

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

6 Nov 1868

9. AGE (in years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Kathryn Noble

17. INFORMANT

ADDRESS

Little Sisters of the Poor

 8. **422.1 I**  
 DISEASE OR CONDITION DIRECTLY  
 LEADING TO DEATH  
 (This does not mean the mode of dying, e. g.,  
 heart failure, asphyxia, etc. It means the disease,  
 injury or complication which caused death.)

#### ANTECEDENT CAUSES

 DISEASES OR CONDITIONS, IF ANY, GIVING  
 RISE TO THE ABOVE CAUSE (A) STATING THE  
 UNDERLYING CONDITION LAST.

#### CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1 month

1 year

II

 OTHER SIGNIFICANT CONDITIONS CON-  
 TRIBUTING TO THE DEATH, BUT NOT RELATED  
 TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from June 19, 1953, to July 19, 1953, that I last saw the  
 deceased alive on July 18, 1953, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. G. Hall M.D.

23B. ADDRESS

1631 E North Ave

23C. DATE SIGNED

July 20-53

BURIAL, CREMA-  
TION (Specify)

24B. DATE

7-22-53

24C. NAME OF CEMETERY OR CREMATORY

Cathedral City

24D. LOCATION (City, town, or county)

City

(State)

RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Greenmount 822 N. H.

UL 22-1953

VS 150

1952

1868

- 84

5-120  
53 6660BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6660  
Registered No.

TH NO.

|   |                               |  |                                   |
|---|-------------------------------|--|-----------------------------------|
| 1. NAME OF DECEASED<br>(Last, first, middle, or Print) <b>Jessie SAVAGE, Jr.</b>  |                               | 2. DATE OF DEATH <b>7-22-53</b>  |                                   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland Baltimore</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>25-33</b> |                                   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>2601 Ridgley Street</b> |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |                                   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>40 years.</b>  |                               | D. STREET ADDRESS (If rural, give location)<br><b>2601 Ridgley Street</b>  |                                   |
| 7. SEX <b>Male</b>  | 8. COLOR OR RACE <b>Negro</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Separated</b>  | 10. DATE OF BIRTH <b>12-22-13</b> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>Chauffeur</b>             |                               | 12. AGE (In years last birthday) <b>40</b>   |                                   |
| 13. FATHER'S NAME<br><b>Jessie SAVAGE, sr.</b>  |                               | 14. BIRTHPLACE (State or foreign country)<br><b>Baltimore, md.</b>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                               | 16. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                   |
| 17. SOCIAL SECURITY NO.   |                               | 18. MOTHER'S MAIDEN NAME<br><b>Alice Johnson</b>   |                                   |
| 19. INFORMANT<br><b>Alice SAVAGE, Same</b>  |                               | 20. ADDRESS<br><b>Same</b>   |                                   |

|  |  |                      |  |                                  |  |
|--|--|----------------------|--|----------------------------------|--|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH       |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) ANTECEDENT CAUSES  |  | Pneumonia lobar      |  | 3 days                           |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (B) Koch's Infection |  | 3 mo                             |  |
|  |  | (C) Hemorrhage       |  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                      |  |                                  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>July 16, 1953</b> , to <b>July 22, 1953</b> , that I last saw the deceased alive on <b>July 21, 1953</b> , and that death occurred at <b>3:30 a. m.</b> , from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE<br><b>John L. Luck</b>   |  | 23B. ADDRESS<br><b>427 Swale ave.</b>  |  | 23C. DATE SIGNED<br><b>7-22-53</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7/25/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |  | 25. FUNERAL DIRECTOR<br><b>Charles R. Rice</b>   |  | 25. ADDRESS<br><b>661 W. Burre St.</b>                                   |  |
| 26. RECEIVED BY AL REGISTRAR<br><b>Huntington Williams</b>  |  | 27. DATE<br><b>7-22-1953</b>   |  | 28. SIGNATURE<br><b>68352</b>  |  |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6661  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

c. Length of stay in Baltimore

5. SEX

6. COLOR OF RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 4, 1951, to July 21, 1953, that I last saw the  
deceased alive on July 21, 1953 and that death occurred at 1:50 p. m., from the cause and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

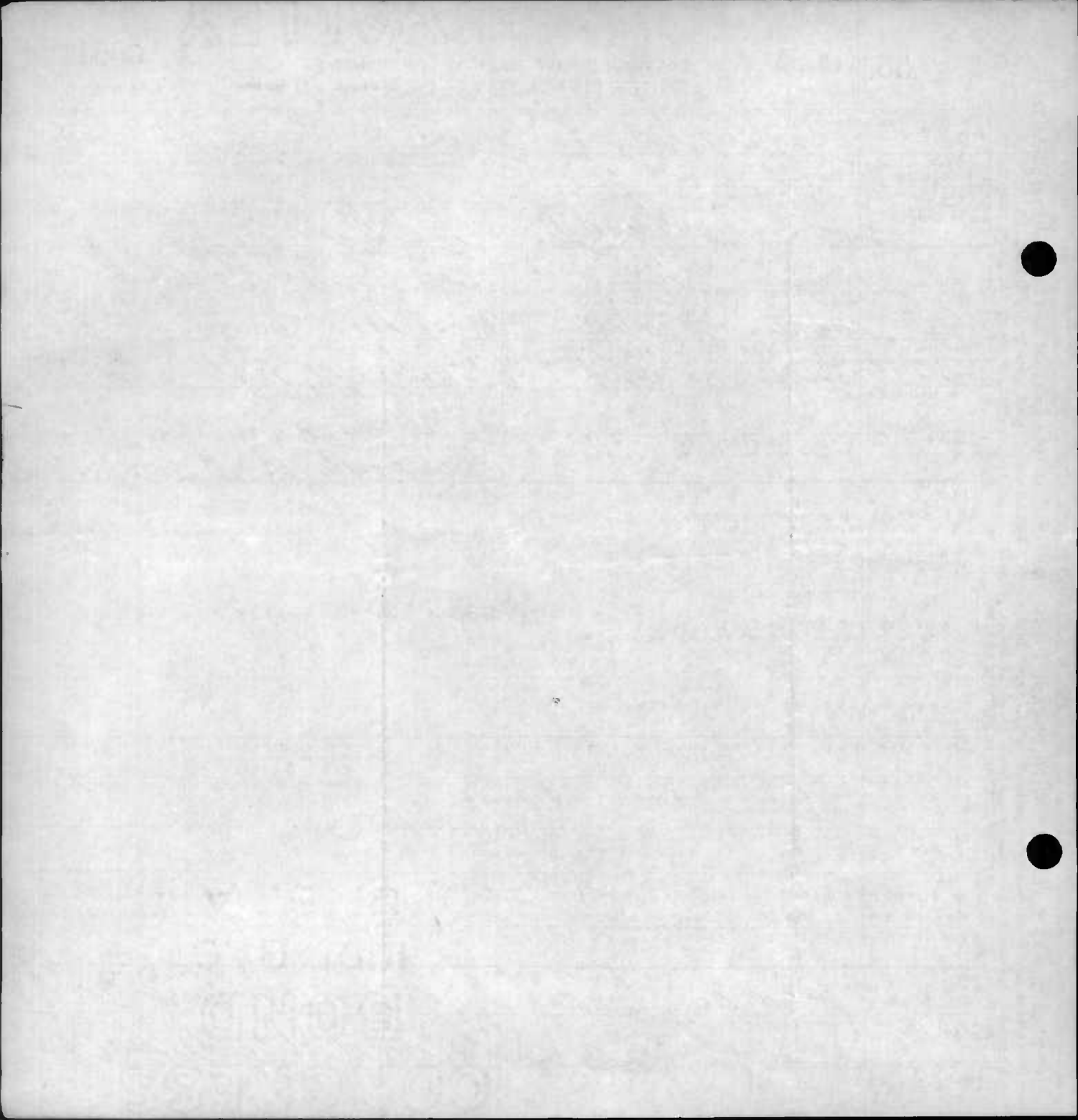
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 22 1953

203 50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6662  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ADELAIDE LILLIAN SPENCER

2. DATE  
OF  
DEATH

July 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2925 Clifton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

O. STREET ADDRESS (If rural, give location)

2925 Clifton Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Sept. 17, 1878

9. AGE (In years, last birthday)

74

10. Under 1 Year  
Months Days

11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. Long Crean

14. MOTHER'S MAIDEN NAME

Catherine Lally

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss Spencer-2925 Clifton Ave.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Bronchopneumonia*

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Cerebrovascular accident, Stroke 4 mo*

(C) DUE TO

*Hypertensive Cardiovascular Undet.*

CERTIFICATION APPROVED BY *Dr. Fisher*

M. D.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CHIEF OF MEDICAL EXAMINER

OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *D. O. A.*, 19\_\_, to \_\_, 19\_\_, that I last saw the deceased alive on \_\_, 19\_\_, and that death occurred at *3:20 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*A. Bradley Daugherty M.D.*

23B. ADDRESS

*3033 W. North Ave*

23C. DATE SIGNED

*7-21-53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/23/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

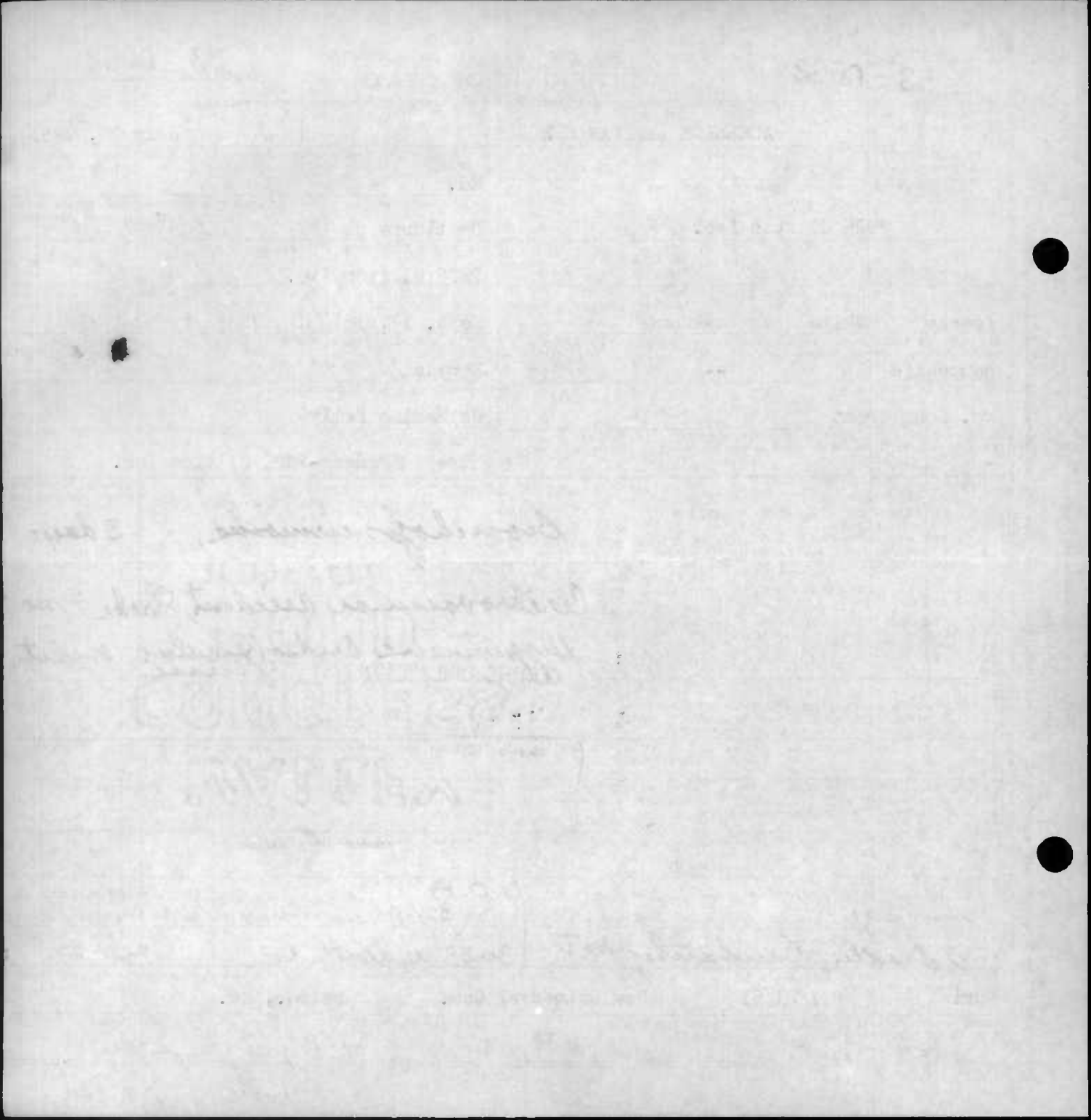
ADDRESS

*Wm. J. Fisher & Sons*

*Balto 17, Md.*

JUL 22 1953 VS 150

MARGIN RESERVED FOR BINDING



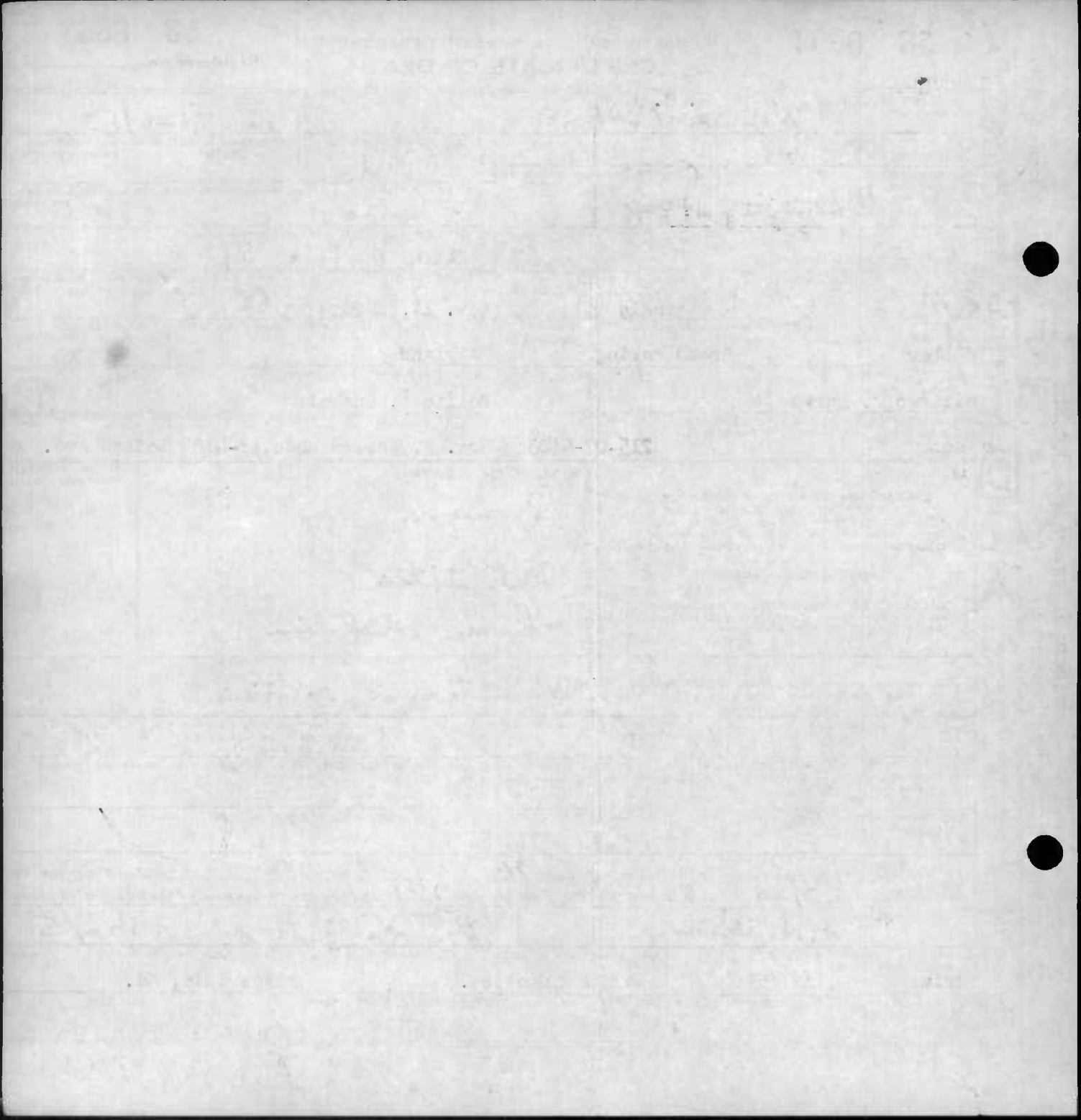
B-630 6663

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6663

Registered No.

|  |                           |  |  |  |  |
|--|---------------------------|--|--|--|--|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM H. B. BURKE</b>  |  | 2. DATE OF DEATH <b>7/20/53</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> |  | B. COUNTY  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>University Hosp.</b>  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b>                |  | D. STREET ADDRESS (If rural, give location)<br><b>201 N. Pine St.</b>    |  |
| c. Length of stay in Baltimore <b>?</b>  |                           | Yrs. Mos. Days   |  | 8. DATE OF BIRTH<br><b>Nov. 17, 1890</b>                                 |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>   |  | 9. AGE (In years last birthday) <b>62</b>                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Jobber</b>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bread making</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |  |
| 13. FATHER'S NAME<br><b>Millard F. Burke</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>Mollie E. Cassell</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>  |                           | 16. SOCIAL SECURITY NO.<br><b>215-07-5503</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. F. Edward Wheeler-4107 Roland Ave.</b>  |  |
| 18. <b>307 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia</b>  |                           | CAUSE OF DEATH<br>(A) <b>Pneumonia</b><br>DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Malnutrition</b>  |                           | (B) <b>Chronic alcoholism</b><br>DUE TO  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Tetanus, epistaxis</b>  |                           |  |  |  |  |
| 19A. DATE OF OPERATION <b>7/18</b>   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>7/18</b> , 19 <b>53</b> , to <b>7/20</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>53</b> , and that death occurred at <b>7:45 P.</b> m., from the causes and on the date stated above. |                           |  |  |  |  |
| 23A. SIGNATURE<br><b>J. W. Uelie</b>   |                           | 23B. ADDRESS<br><b>University Hosp.</b>  |  | 23C. DATE SIGNED<br><b>7/20/53</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 24B. DATE<br><b>7/23/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>            |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b>  |                           | 24E. FUNERAL DIRECTOR<br><b>Wm. J. Vickener &amp; Sons</b>   |  | 24F. ADDRESS   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                           | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR ADDRESS   |  |
| VS 150   |                           | 290 44   |  | Balto. 17, Md.   |  |





C-650  
53 6664BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6664  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Samuel A. Crum

2. DATE  
OF  
DEATH

7/21/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION38 University Hospital  
Baltimore - 1, Maryland

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 29, 1882

9. AGE (In years  
last birthday)

71

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Supt.

10B. KIND OF BUSINESS OR  
INDUSTRY

Picture Frame Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Crum

14. MOTHER'S MAIDEN NAME

Mary -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215-01-7954

17. INFORMANT

ADDRESS

Mrs. Edna W. Crum-622 McKewin Ave.

18. 462x  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONOITDINS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

6/26/53 1

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED,

Benign Prostatic Hypertrophy

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1953, to 7/21, 1953 that I last saw the  
deceased alive on 7/21, 1953, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Walter H. Byerly M.D.

23B. ADDRESS

University Hospital, Balt., Md.

23C. DATE SIGNED

7/21/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/24/53

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn C em.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter H. Byerly M.D.

25. FUNERAL DIRECTOR

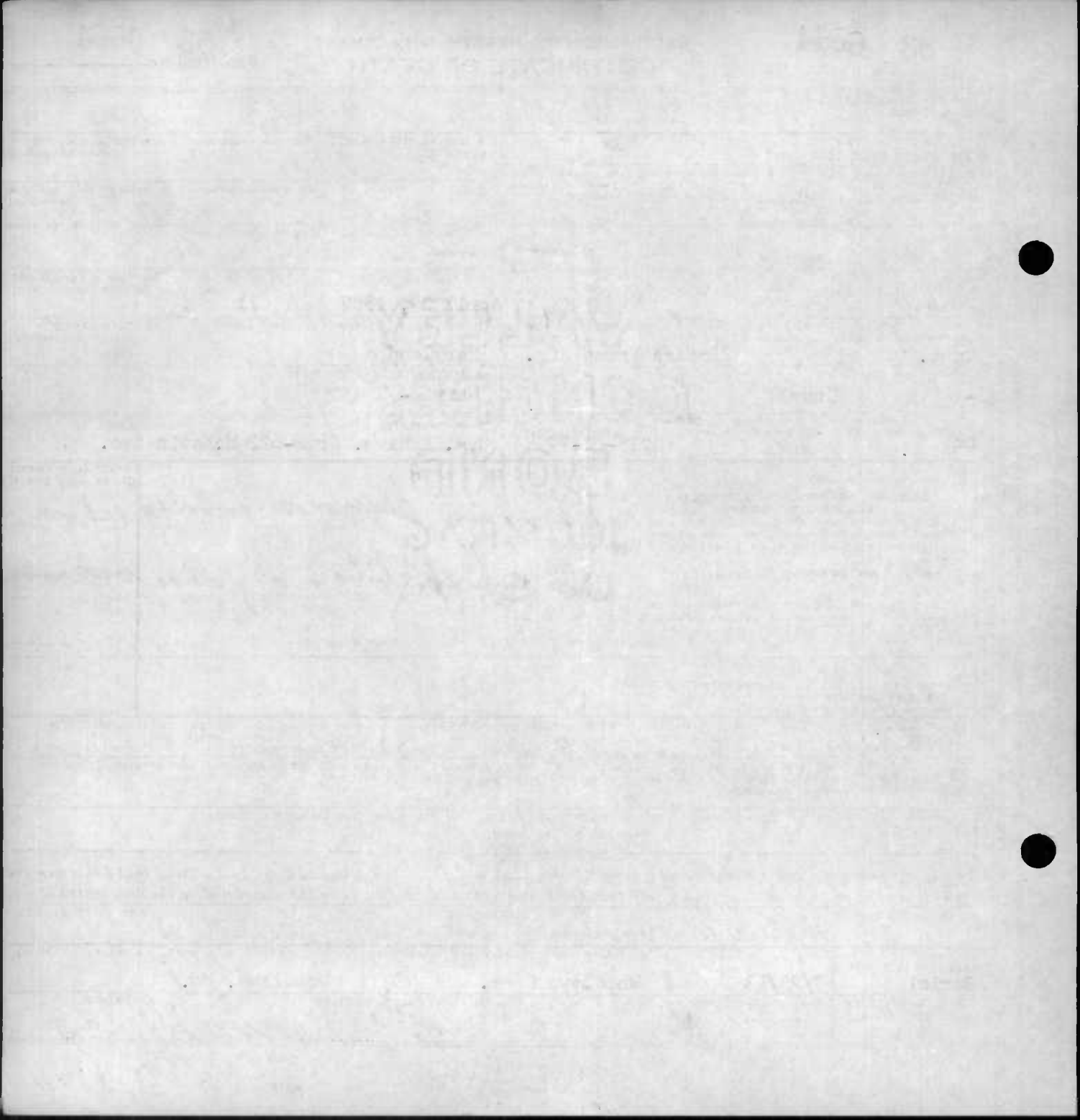
Wm. J. Pickner &amp; Sons

ADDRESS

Baltimore, Md.

VS 150

29084



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 6665**

**5-362**  
BIRTH NO. **53 6665**

|   |                                    |   |   |  |   |
|---|------------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Cassie Stokes</b>   |                                    |   | 2. DATE OF DEATH <b>July 21, 1953</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (if not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b> <b>16-02</b>            |  |   |
| c. Length of stay in Baltimore  |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>1534 W. Lammale St.</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>6-18-96</b>  | 9. AGE (In years last birthday)<br><b>57</b> | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>                                |                                    |   | 11. BIRTHPLACE (State or foreign country)<br><b>Howard Co. Maryland</b>   |  |   |
| 13. FATHER'S NAME<br><b>William Smith</b>   |                                    |   | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Annie Smith</b>  |                                    |   | 17. INFORMANT ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)                                     |                                    | 16. SOCIAL SECURITY NO.   |   |  |   |

|  |   |  |
|--|---|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH<br><b>Myocardial Infarction</b>                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs.</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (A) DUE TO<br>(B) DUE TO<br>(C) <b>Generalized arteriosclerosis</b> |  |

|   |   |  |
|---|---|--|
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                          |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **7-16, 1953**, to **7-21, 1953**, that I last saw the deceased alive on **7-21, 1953**, and that death occurred at **4:05 p.m.** from the causes and on the date stated above.

|   |   |                                    |
|---|---|------------------------------------|
| 23A. SIGNATURE<br><b>W. E. Matthews</b> | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b> | 23C. DATE SIGNED<br><b>7-21-53</b> |
|---|---|------------------------------------|

|  |   |   |  |
|--|---|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/25/53</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>est Liberty Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Marrastivelle, Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 22 1953</b>     | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Arlington S. Phillips</b>              | ADDRESS<br><b>1808 N. Monroe</b>   |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6666  
Registered No.

53 6666

NAME OF DECEASED  
(Last, first, middle, or Print)

Mary Cohen

2. DATE  
OF  
DEATH

7/21/53

PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Swai Hosp. - Balto.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

6. COLOR OR RACE

Female White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

Tailor

10b. KIND OF BUSINESS OR  
INDUSTRY

Shop

FATHER'S NAME

Simon Cohen

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

212-076445A

8. DATE OF BIRTH

1886

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Mins.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Sarah Cohen

17. INFORMANT

ADDRESS

Harry Cohen - 549 S. Monroe St.

18. 443X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Cerebro-vascular accident

INTERVAL BETWEEN  
ONSET AND DEATH

8d.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) DUE TO

Hypertensive Cardio-vasc. Dis

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 17, 1953 to July 21, 1953 that I last saw the deceased alive on July 21, 1953 and that death occurred at 2:00 pm., from the causes and on the date stated above.

23a. SIGNATURE

Daniel Bakal

23b. ADDRESS

Swai Hosp

23c. DATE SIGNED

7/21/53

BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

7/23/53

24c. NAME OF CEMETERY OR CREMATORY

City Chaim

24d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

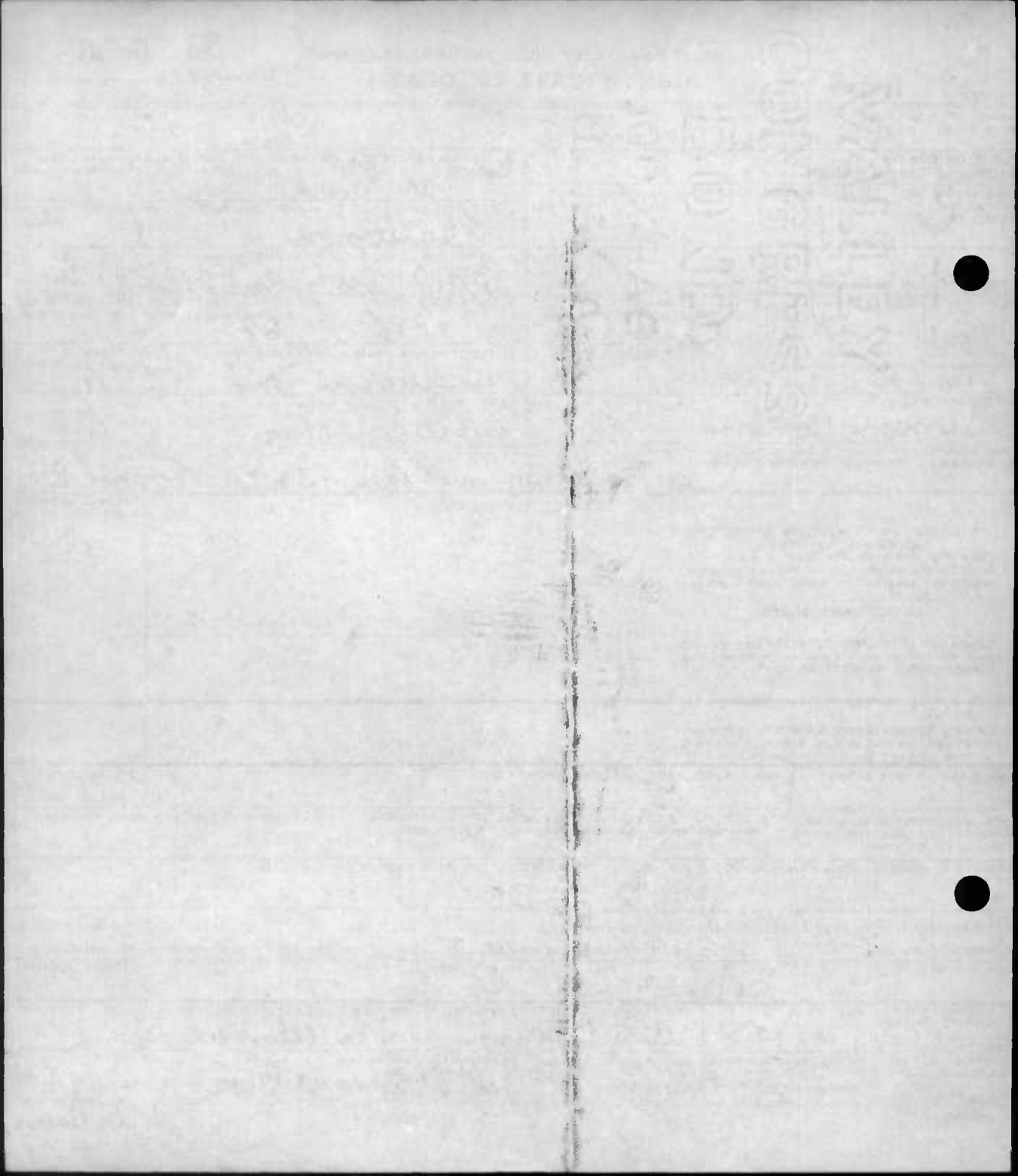
ADDRESS

Sol. Levinson - Broz - 1124-26 W

North Avenue

VS-150

5906E





| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                           |   |   | 53 6667<br>Registered No.   |  |
|--|---------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Full name or Print) <b>BUECHE, MR. CHARLES</b>   |                           |   |   | 2. DATE OF DEATH <b>July 21, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                           |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>SPITAL OR INSTITUTION <b>Home &amp; Hospital</b>   |                           |   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6-03</b>  |  |
| 6. Length of stay in Baltimore <b>77</b>   |                           |   |   | D. STREET ADDRESS (If rural, give location) <b>2123 Mayer St.</b>   |  |
| 7. SEX <b>M</b>  | 8. COLOR OR RACE <b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>  | 10. DATE OF BIRTH <b>May 7, 1876</b>                      | 11. AGE (In years last birthday) <b>77</b>  | 12. Under 1 Year Months: Days: Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) <b>Retired</b>   |                           |   | 14. BIRTHPLACE (State or foreign country) <b>Maryland</b> |   |  |
| 15. FATHER'S NAME <b>Mr. Charles Bueche</b>  |                           |   | 16. MOTHER'S MAIDEN NAME <b>Sadie Taylor</b>              |   |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>  |                           |   | 18. SOCIAL SECURITY NO. <b>-</b>                          |   |  |
| 19. INFORMANT <b>Home &amp; Hospital</b>   |                           |   | 20. ADDRESS <b>Home &amp; Hospital</b>                    |   |  |
| 21. CAUSE OF DEATH   |                           |   |   | 22. INTERVAL BETWEEN ONSET AND DEATH  |  |
| (A) <b>Myocardial Infarction</b>   |                           |   |   | <b>1 day</b>  |  |
| (B) <b>Arteriosclerotic Heart Disease</b>  |                           |   |   | <b>yes</b>  |  |
| (C) <b>Generalized Arteriosclerosis</b>  |                           |   |   | <b>yes</b>  |  |
| 23. ANTECEDENT CAUSES  |                           |   |   |   |  |
| 24. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                           |   |   |   |  |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |   |   |   |  |
| 26. DATE OF OPERATION <b>7/20</b>  |                           | 27. MAJOR FINDINGS OF OPERATION   |   | 28. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                           | 30. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |   | 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 32. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 34. HOW DID INJURY OCCUR?   |  |
| 35. I hereby certify that I attended the deceased from <b>7/20</b> , 19 <b>53</b> to <b>7/21</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/21</b> , 19 <b>53</b> , and that death occurred at <b>7:05 P.M.</b> , from the causes and on the date stated above. |                           |   |   |   |  |
| 36. SIGNATURE <b>David F. Dawson</b>   |                           | 37. ADDRESS <b>Home &amp; Hospital</b>  |   | 38. DATE SIGNED <b>7/22/53</b>  |  |
| 39. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |                           | 40. DATE <b>7/24/53</b>   |   | 41. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cem</b>   |  |
| 42. LOCATION (City, town, or county) <b>Bald Md</b>  |                           | 43. STATE <b>Md</b>   |   | 44. FUNERAL DIRECTOR <b>Paul O. Newman</b>  |  |
| 45. RECEIVED BY CAL REGISTRAR <b>Huntington Hall</b>   |                           | 46. REGISTRAR'S SIGNATURE   |   | 47. ADDRESS <b>6067 Hayford Rd</b>  |  |

STATE OF NEW YORK

1900

IN SENATE,  
January 1, 1900.

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE,  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899.

ALBANY:  
J. B. LEECH, STATE PRINTER,  
1899.

C-120  
53 6668

53 6668

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| TH NO.   |  | NAME OF DECEASED<br>(Please Print)  |  | 2. DATE OF DEATH   |  |
|  |  | Robert F. Cephas  |  | July 29, 1953  |  |
| PLACE OF DEATH:  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                             |  |  |  |
| Baltimore City, Maryland   |  | A. STATE: Md. B. COUNTY: _____  |  |  |  |
| FULL NAME OF DECEASED<br>(If not in hospital or institution, give street address or location)  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                                      |  |  |  |
| 911 W. Franklin St.  |  | Balto. 18-01  |  |  |  |
| Length of stay in Baltimore  |  | D. STREET ADDRESS (If rural, give location)   |  |  |  |
|  |  | 911 W Franklin St.  |  |  |  |
| SEX  |  | 6. COLOR OR RACE  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                          |  |
| Male   |  | Col.  |  | Married (Sep)  |  |
| 8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday)  |  |
| Clerk  |  |   |  | 25   |  |
| FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| George Cephas  |  | Elise Cephas  |  | U.S.A.   |  |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| Yes  |  | Korean  |  | Elsie Coates 911 W Franklin St.  |  |
| 18. 353.3  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                        |  | (A) Pulmonary hemorrhage  |  | 7/30/53 A.M.   |  |
| ANTECEDENT CAUSES  |  | (B) Epileptoid fits   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (C)   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| None   |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
|  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from 7/13, 1953, to 7/18, 1953, that I last saw the deceased alive on 7/18, 1953, and that death occurred at _____ m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE   |  | 23B. ADDRESS  |  | 23C. DATE SIGNED   |  |
| H. Williams  |  | 1515 Harlem Ave   |  | 7/21/53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial   |  | 7/29/53   |  | Balto National   |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)                            |  |
|  |  |   |  | Balto Md   |  |
| 25. FUNERAL DIRECTOR   |  | ADDRESS   |  |  |  |
| Mrs Katie R. Williams Schroeder  |  | 322 N   |  |  |  |
| VS 150   |  | Huntington Waltham 39099  |  |  |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DEATH CERTIFICATE

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Witness

Signature of Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 6669**

BIRTH NO. **53-06139**

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Gingles, Avalon</b>   |                                 | 2. DATE OF DEATH <b>7/19/53</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                 | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>P</b> |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Univ. Hospital</b> |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 4-02</b>                                   |   |
| c. Length of stay in Baltimore <b>4 months</b>  |                                 | D. STREET ADDRESS (If rural, give location)<br><b>744 W. Fayette ST.</b>  |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH <b>March 15, 1953</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>   |                                 | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>4</b><br>If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min. |
| 13. FATHER'S NAME<br><b>James Elkins Gingles</b>  |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>Balta Md.</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>                                    |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 16. SOCIAL SECURITY NO.   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Mildred Johnson</b>  |   |
| 17. INFORMANT<br><b>Mildred Johnson - Fayette St.</b>   |                                 | ADDRESS <b>744 W.</b>   |   |

|   |  |                                   |  |                                  |  |
|---|--|-----------------------------------|--|----------------------------------|--|
| 18. <b>491X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH                    |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) <b>Bronchopneumonia</b>   |  | DUE TO                            |  | <b>?</b>                         |  |
| ANTECEDENT CAUSES   |  | (B) <b>Overwhelming Infection</b> |  | DUE TO                           |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (C)                               |  |                                  |  |

|  |  |
|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
|--|--|

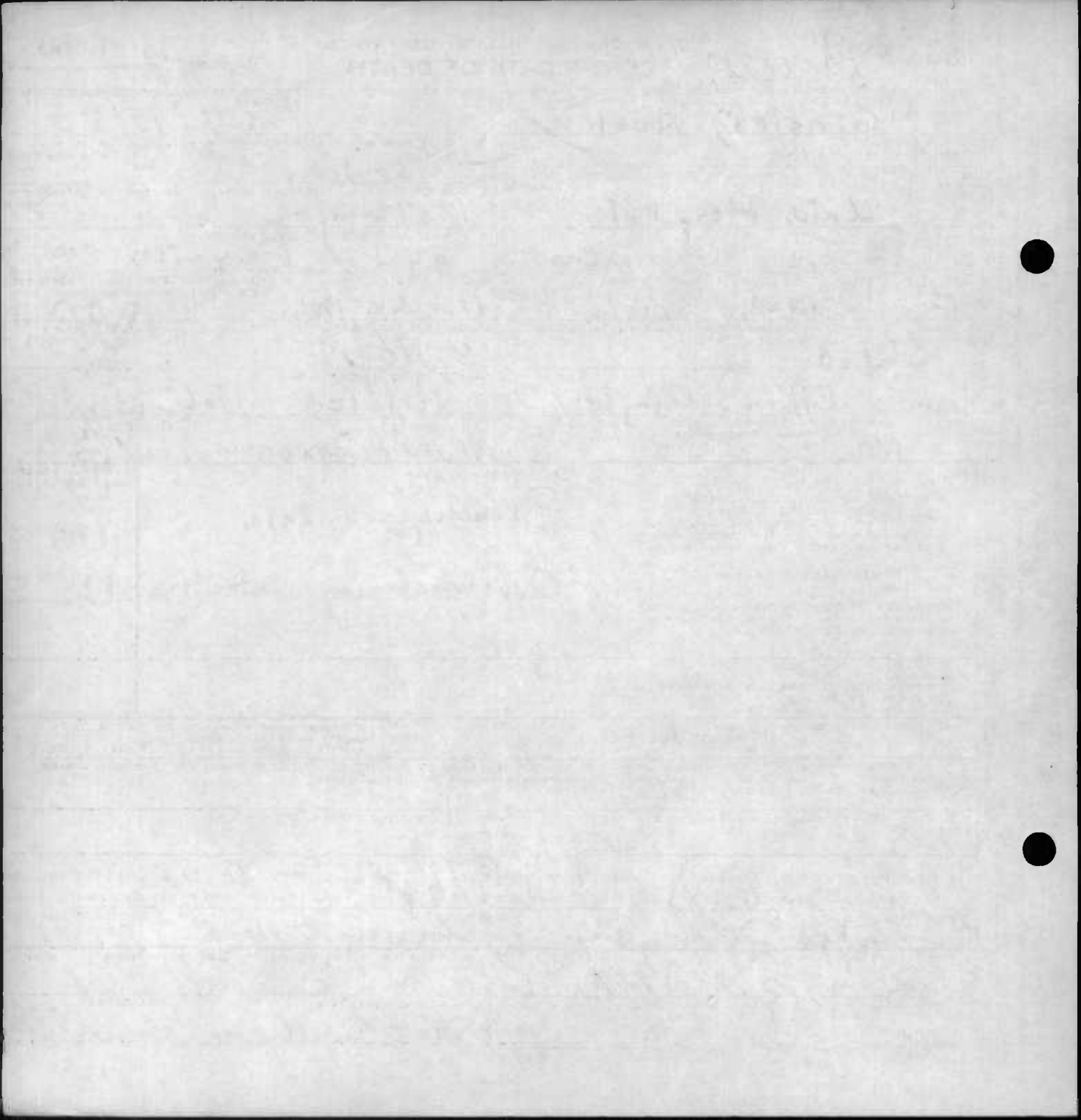
|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |

22. I hereby certify that I attended the deceased from **July 19, 1953** to **July 19, 1953**, that I last saw the deceased alive on **July 19, 1953** and that death occurred at **9:10 p.m.**, from the causes and on the date stated above.

|   |  |   |  |                                    |  |
|---|--|---|--|------------------------------------|--|
| 23A. SIGNATURE<br><b>Shirley Sherman M.D.</b> |  | 23B. ADDRESS<br><b>University Hosp.</b> |  | 23C. DATE SIGNED<br><b>7/19/53</b> |  |
|---|--|---|--|------------------------------------|--|

|   |  |                               |  |   |  |  |  |
|---|--|-------------------------------|--|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) |  | 24B. DATE<br><b>7/23/1953</b> |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Cem. Balto.</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |  |
|---|--|-------------------------------|--|---|--|--|--|

|                                  |  |   |  |   |  |                       |  |
|----------------------------------|--|---|--|---|--|-----------------------|--|
| DATE RECEIVED BY LOCAL REGISTRAR |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>Mrs. Kate Williams - Schroeder</b> |  | ADDRESS <b>322 N.</b> |  |
|----------------------------------|--|---|--|---|--|-----------------------|--|





M-210  
53 6670

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH 334X

53 6670  
Registered No. ....

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 6000 Bellona Ave., (12)
- (c) Hospital or institution:  
Algewood Nursing Home,
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs.
- (e) Length of stay in Baltimore (yrs., mos., or days) .....

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County .....
- (c) City or town Baltimore 29  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 518 Denison St 2-0-07  
(If rural give location)
- (e) Citizen of foreign country? ....., (Ycs or No)  
If yes, name country .....

## 3 (a) FULL NAME

Mrs. Emma McVey,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widow
- 6 (b) Name of husband or wife Late Absalon McVey  
6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1861
8. AGE: Years 91 Months 10 Days 10 If less than one day  
\_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Balto, Md.  
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

12. Name ----- Coleman13. Birthplace Unknown14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Miss Alma L. McVey(b) Address 518 Denison St.

- 17 (a) Burial (b) Date thereof July 23/53  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn  
Location Woodlawn 7, Balto, Md.

18 (a) Funeral director Harry H. Witzke(b) Address 4101 Edmondson Ave.

19 (a) William H. Williams, M.D. (b) William H. Williams, M.D.  
(Date recd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 19 53 at 5:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 53 to July 21, 1953, and that I last saw him alive on July 16, 1953.

Immediate cause of death

Cerebral sclerosis.

Duration

Due to Arteriosclerosis.Due to Senility.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence \_\_\_\_\_ at \_\_\_\_\_ M
- (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_  
(Specify type of place)

(e) Means of injury

23. Signature Dr. Corbin StreetAddress 712 Park Ave.,M. D. 7/21/53  
Date signed

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6671  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

BOALS

(Boles)

2. DATE  
OF  
DEATH

July 20, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

222 S. Hanover Street

c. Length of stay in Baltimore

18 YRS.

Yrs.  
Mos.  
Days5. SEX  
male6. COLOR OR RACE  
white7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

May 24, 1887

9. AGE (in years  
last birthday)

66

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PLASTERER

10B. KIND OF BUSINESS OR  
INDUSTRY

Bldg. Const.

11. BIRTHPLACE (State or foreign country)

FLORIDA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE BOLES

14. MOTHER'S MAIDEN NAME

ALICE MOORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

P

17. INFORMANT

Roy A. Seigler

ADDRESS

Glenndale, Md

18. 002X and 322.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Tuberculosis, bilateral

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an partial autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

7-20-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

CREMATION

24B. DATE

7-22-53

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

BALTIMORE, MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

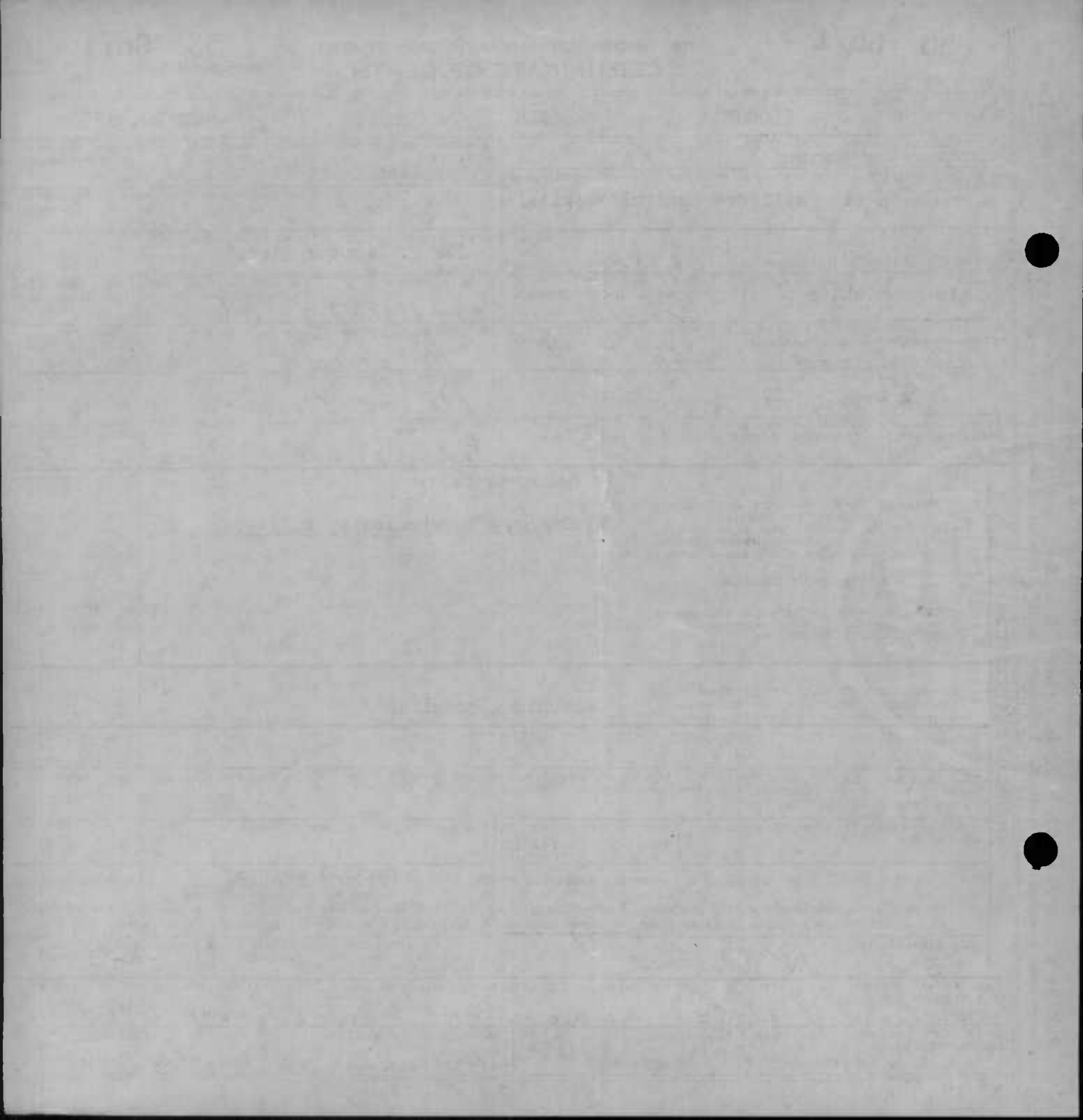
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

George L. Schwab 2101 Frederick Ave

ADDRESS



-652.  
53 6672

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6672  
Registered No.

TH NO.

|  |                                  |  |  |   |  |   |  |
|--|----------------------------------|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Last, first, middle, or Print) <b>BRANCH, MR. ZACKIE</b>   |                                  |  |  | 2. DATE OF DEATH <b>JULY 20, 1953</b>   |  |   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                                  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>—</b> |  |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>CHURCH HOME and HOSPITAL</b>   |                                  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b>  |  |   |  |
| 6. Length of stay in Baltimore <b>30</b> (Yrs. Mos. Days)  |                                  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>631 NORTH DUNCAN STREET</b>   |  |   |  |
| 7. SEX<br><b>MALE</b>  | 8. COLOR OR RACE<br><b>WHITE</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>                                      | 10. DATE OF BIRTH<br><b>August 28, 1896</b>            |   | 11. AGE (in years last birthday)<br><b>56</b>                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                     |  |
| 13. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)<br><b>BARTENDER</b>   |                                  |  | 10a. KIND OF BUSINESS OR INDUSTRY<br><b>Stable Bar</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b> |   |  |
| 14. FATHER'S NAME<br><b>BRANCH, ?</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>EUMERY, MOLLY</b>       |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>   |                                  |  | 16. SOCIAL SECURITY NO.<br><b>217 -01-0124</b>         |   | 17. INFORMANT ADDRESS<br><b>MRS. ANNA BRANCH SAME</b>              |   |  |
| 18. <b>420.1 and 016X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCTION</b><br>DUE TO <b>CORONARY OCCLUSION</b> |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |  |   |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>UREMIA (TRX of KIDNEY)</b>  |                                  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>JULY 8, 1953</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>TUBE ARTERIOSCLEROSIS OF KIDNEY</b>                             |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><b>No</b>   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>JULY 6, 1953</b> , to <b>JULY 20, 1953</b> , that I last saw the deceased alive on <b>JULY 20, 1953</b> , and that death occurred at <b>10:20pm.</b> , from the causes and on the date stated above.                                   |                                  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>C. Burton Galloway</b>  |                                  |  |  | 23B. ADDRESS<br><b>CHURCH HOME &amp; HOSPITAL</b>   |  | 23C. DATE SIGNED<br><b>JULY 20, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>JULY 23, 1953</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>              |  |
| 25. RECEIVED BY<br>REGISTRAR   |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>   |  | ADDRESS<br><b>2601-3-5 E. Madison St.</b>   |  |

VS 1503

750 64

Dr. Silberman, Director FBC Bureau BCED spoke to  
Dr. Galloway, Church Home and Hospital about the sequence of  
events in this case. Decent had had 2 or 3 previous heart attacks.

See Document File for memo in this dept.

6/4/53 ES



7-620  
53 6673

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6673  
Registered No.

IRTH NO.

NAME OF DECEASED  
(or Print)

JOSEPH ZARAS

2. DATE  
OF DEATH July 21, 1953

PLACE OF DEATH:

Baltimore City, Maryland 2218 E. Prentiss Place

3. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2218 E. Prentiss Place

Length of stay in Baltimore

50 yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)

City Builder

10B. KIND OF BUSINESS OR INDUSTRY

Warner Fruehauf

FATHER'S NAME

Thomas Zaras

TRAILERS (4)

8. DATE OF BIRTH

March 18, 1887

9. AGE (In years last birthday)

66

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

unknown

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Anna Cernohorsky Zaras, wife, above

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

5 minutes

3 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1950, to 7/20, 1953, that I last saw the deceased on 7/20, 1953, and that death occurred at 12 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 24, 1953

Oak Hill Cemetery

Horner's Lane, Balto. Md.

25. RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

27. REGISTRAR

Schimunek Funeral Home, Inc.  
2601-3-5 E. Madison St.

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

ANDREW D. DODD, PRINTER

1901

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

ANDREW D. DODD, PRINTER

1901

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

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FOR THE YEAR 1900

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THE STATE OF NEW YORK

IN SENATE

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1901

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

ANDREW D. DODD, PRINTER

1901

THE STATE OF NEW YORK

33653  
33 6614BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6674

Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

Frank

ALLEN BERNAT

2. DATE  
OF  
DEATH

7/21/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

27-48

D. STREET ADDRESS (If rural, give location)

930 NORTHERN PARKWAY

Length of stay in Baltimore

9 1/2 yrs

Yrs.  
Mos.  
Days

SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

Aug. 22, 1943

9. AGE (In years  
last birthday)

9

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

EMIL F. BERNAT

14. MOTHER'S MAIDEN NAME

ELEANORE A. KLINGENBERG

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

—

17. INFORMANT

FATHER

ADDRESS

930 NORTHERN PKWY.

8. 343X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Encephalomalacia (Post-Encephalitic Syndrome) 11 wks.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)

Encephalomyelitis

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1953, to July 21, 1953, that I last saw the deceased alive on July 21, 1953, and that death occurred at 7 A. M., from the causes and on the date stated above.

23A. SIGNATURE

George H. Miller

M. O.

23B. ADDRESS

Mercy Hospital Balto.

23C. DATE SIGNED

July 21, 1953

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

July 24, 1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Horner's Lane, Balto. Md.

RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.

BALTIMORE CITY HEALTH DEPARTMENT  
CENTROLOGICAL DATA

DATE

FILE



STATE OF MARYLAND  
BALTIMORE CITY  
HEALTH DEPARTMENT  
CENTROLOGICAL DATA

REPORT OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORTED BY

SIGNATURE

DATE

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 6675

BIRTH NO. 53 6675 53-16670

1. NAME OF DECEASED  
(Type or Print)

Diana

Lee Bennett

2. DATE  
OF  
DEATH

July 21, 1953

3. PLACE OF DEATH:

a. Baltimore City, Maryland ✓

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION47 Hospital For the Women  
Maryland

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)

A. STATE

B. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 12-02

d. STREET ADDRESS (If rural, give location)

2022 Brookfield Ave.

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 20, 1953

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

24

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALFRED LEE BENNETT

14. MOTHER'S MAIDEN NAME

Helen Lillian Flaherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother - 2022 Brookfield Ave.

18. 762.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Anoxia, undetermined origin 23h 59m.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

M. Cook due to M. K.  
4-6

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21e. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1953, to July 21, 1953, that I last saw the  
deceased alive on July 21, 1953, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE

William Phelphus

23b. ADDRESS

Hon. 100 W. Wm. 8 and 7/21/53

23c. DATE SIGNED

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

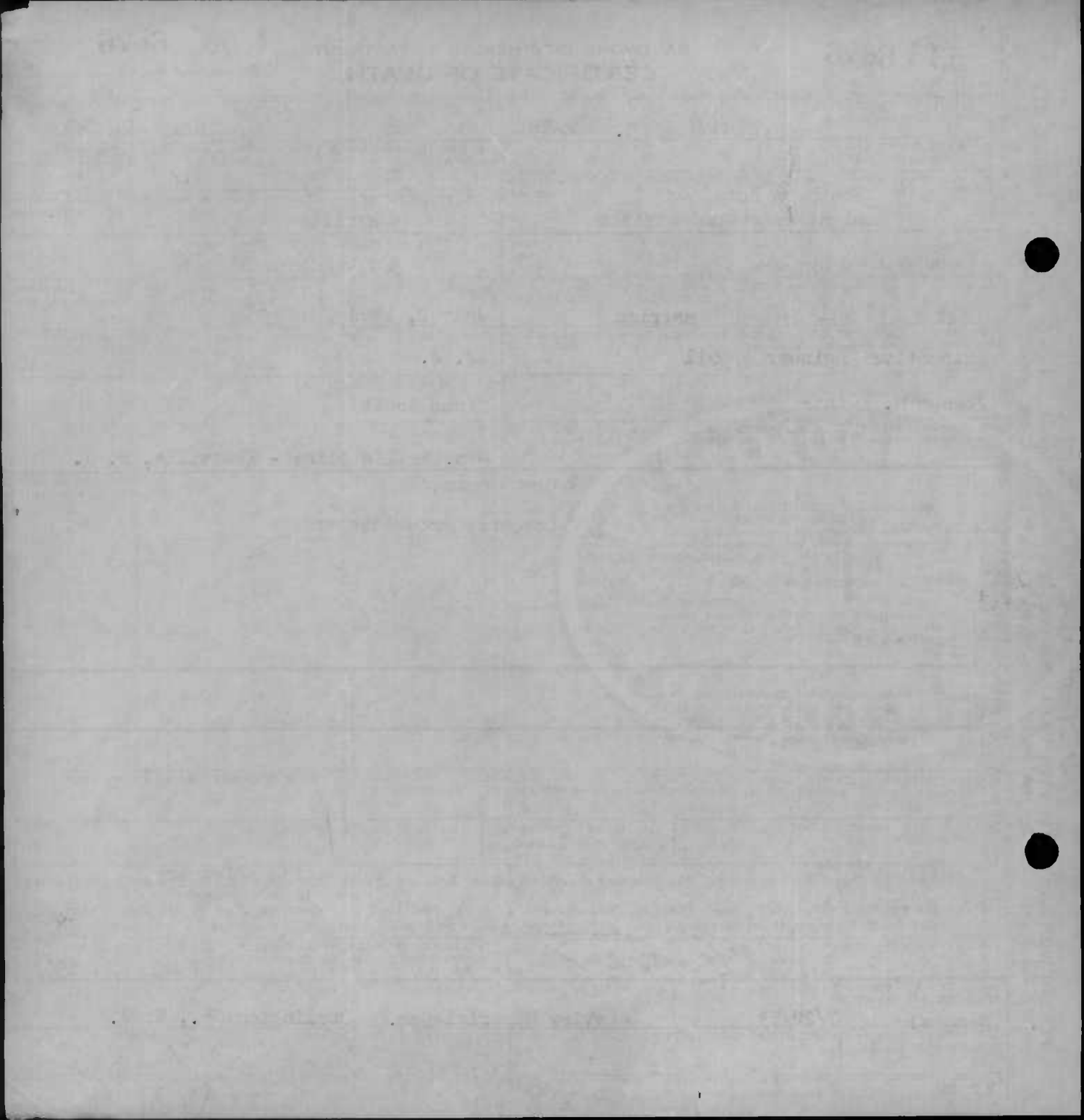
25. FUNERAL DIRECTOR

ADDRESS









625

3 6677

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6677

NAME OF DECEASED  
(Last, first, and middle name or Print)

ALVINA HARRISON

2. DATE  
OF  
DEATH

JULY 21, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

SINAI HOSPITAL INC.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

NOV. 26, 1884

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

AT HOME

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

CHARLES WEBER

14. MOTHER'S MAIDEN NAME

WILHELMINA ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

AUGUST C. WEBER. CHASE, MARYLAND.

18. 570.5 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) PERITONITIS  
DUE TO INTESTINAL OBSTRUCTION

60 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ~~WAS~~ HYPERTENSIVE C.V. DISEASE  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐22. I hereby certify that I attended the deceased from July 21, 1953, to July 21, 1953, that I last saw the  
deceased alive on July 21, 1953, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

William Drouin

M. D.

23B. ADDRESS

Sinai Hosp. Balto, Md

23C. DATE SIGNED

July 21, 1953

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

JULY 25, 1953

24C. NAME OF CEMETERY OR CREMATORY

PARKWOOD

24D. LOCATION (City, town, or county)

PARKVILLE

(State)

MD

25. FUNERAL RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Hartington

25. FUNERAL DIRECTOR

ADDRESS

MULLRICH FUNERAL HOME PUNDACK AV

VS 150



-620

3 6678

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6678

TH NO.

NAME OF DECEASED  
(Please Print)

Henry Erick

2. DATE  
OF  
DEATH

July 20, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hosp.

Yrs.  
Mos.  
Days

of stay in Baltimore

6. COLOR OR RACE

M W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W

8. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

AILOR - RETIRED

10a. KIND OF BUSINESS OR  
INDUSTRY

CLOTHING

FATHER'S NAME

CARL ERICK

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

NO-

16. SOCIAL  
SECURITY NO.

-

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1921 E. 32nd St.

8. DATE OF BIRTH

3/15/65

9. AGE (In years  
last birthday)

88

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

14. MOTHER'S MAIDEN NAME

MARTHA STAUFF

17. INFORMANT

ADDRESS

MRS. BERTHA MILLER- 1921 E. 32nd St.

18. 443x 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Encephalopathy

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

7-18-53 to 7-20-53

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Heart Disease

DUE TO

1921 7-20-53

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Generalized Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1953, to July 20, 1953, that I last saw the  
deceased alive on July 20, 1953, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Eustace del Camps

M. D.

23B. ADDRESS

South Baltimore General Hospital

23C. DATE SIGNED

7-20-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

URIAL

24B. DATE

JULY 23, 1953

24C. NAME OF CEMETERY OR CREMATORY

LORRAINE

24D. LOCATION (City, town, or county)

WOOD LAWN MD

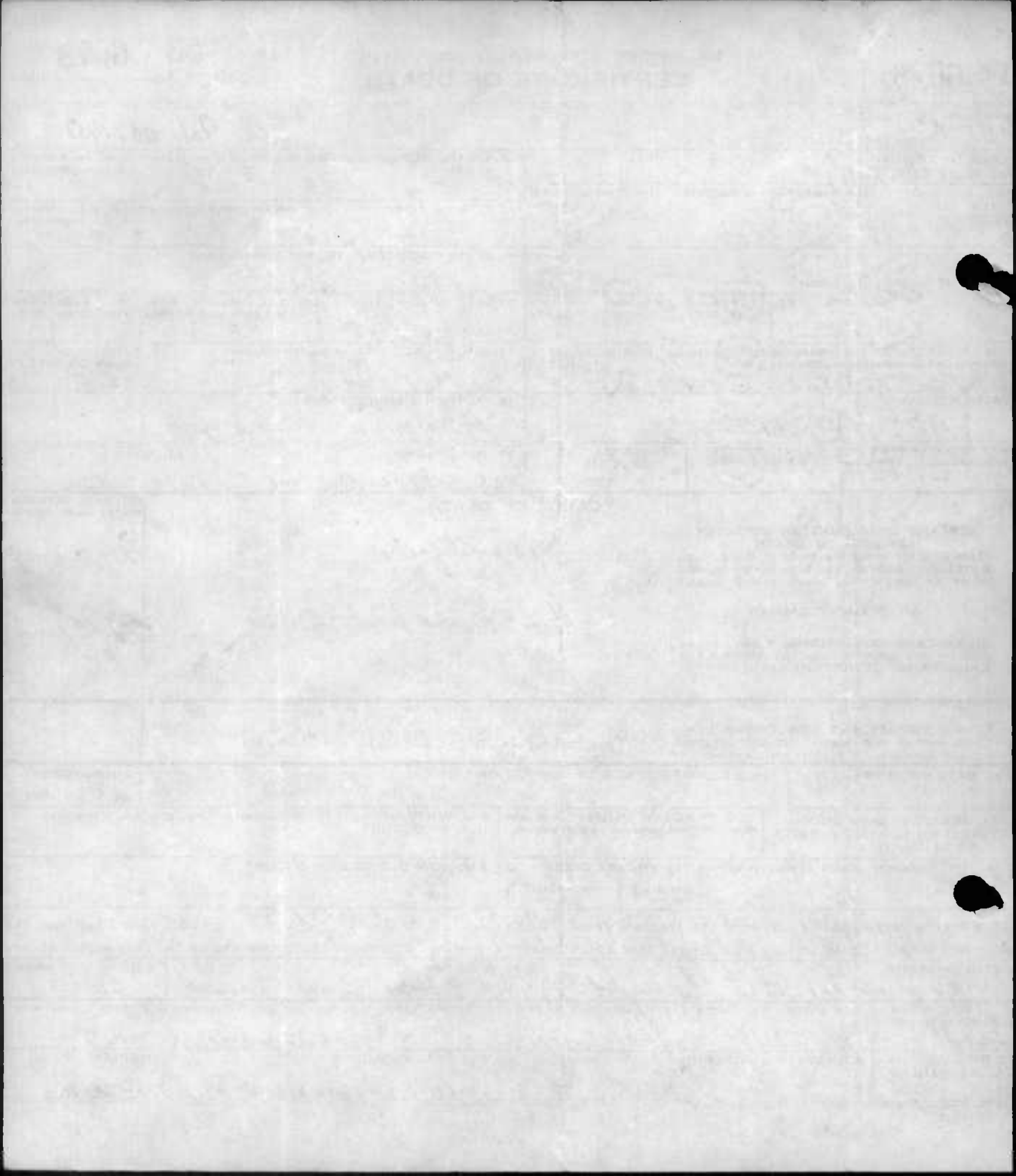
(State)

25. FUNERAL DIRECTOR

ADDRESS

25. FUNERAL DIRECTOR

ULLRICH FUNERAL HOME 2112 DUNDALK





-431

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6679

No. 6679

NAME OF DECEASED  
(Last, first, middle, or Print)

FOLIG, GOLDFINGER

2. DATE  
OF  
DEATH

7-21-53

PLACE OF DEATH:

Baltimore City, Maryland 4613 Park Hyle

FULL NAME OF (If not in hospital or institution, give street address or location)

Mt Sinai Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY 27-16

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4546 Amlico Road

Length of stay in Baltimore

40

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Morton

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

88

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Aycia

17. INFORMANT

Sara Gordon

ADDRESS

Same

8. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute Coronary Infarction

DUE TO

ANTECEDENT CAUSES

(B) \_\_\_\_\_

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE, (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 7/21, 1953, to 7/21, 1953, that I last saw the  
deceased alive on 7/21, 1953 and that death occurred at 4:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

7/21/53

24. BURIAL, CREMA-  
TIONAL (Specify)

Burial

24B. DATE

July 23, 1953

24C. NAME OF CEMETERY OR CREMATORY

Mt Carmel

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

RECEIVED BY  
REGISTRAR'S SIGNATURE

AL REGISTRAR

Huntington

25. FUNERAL DIRECTOR

J. L. Lewis Inc - 2100 Eutan Pe

ADDRESS

MINNAPOLIS CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

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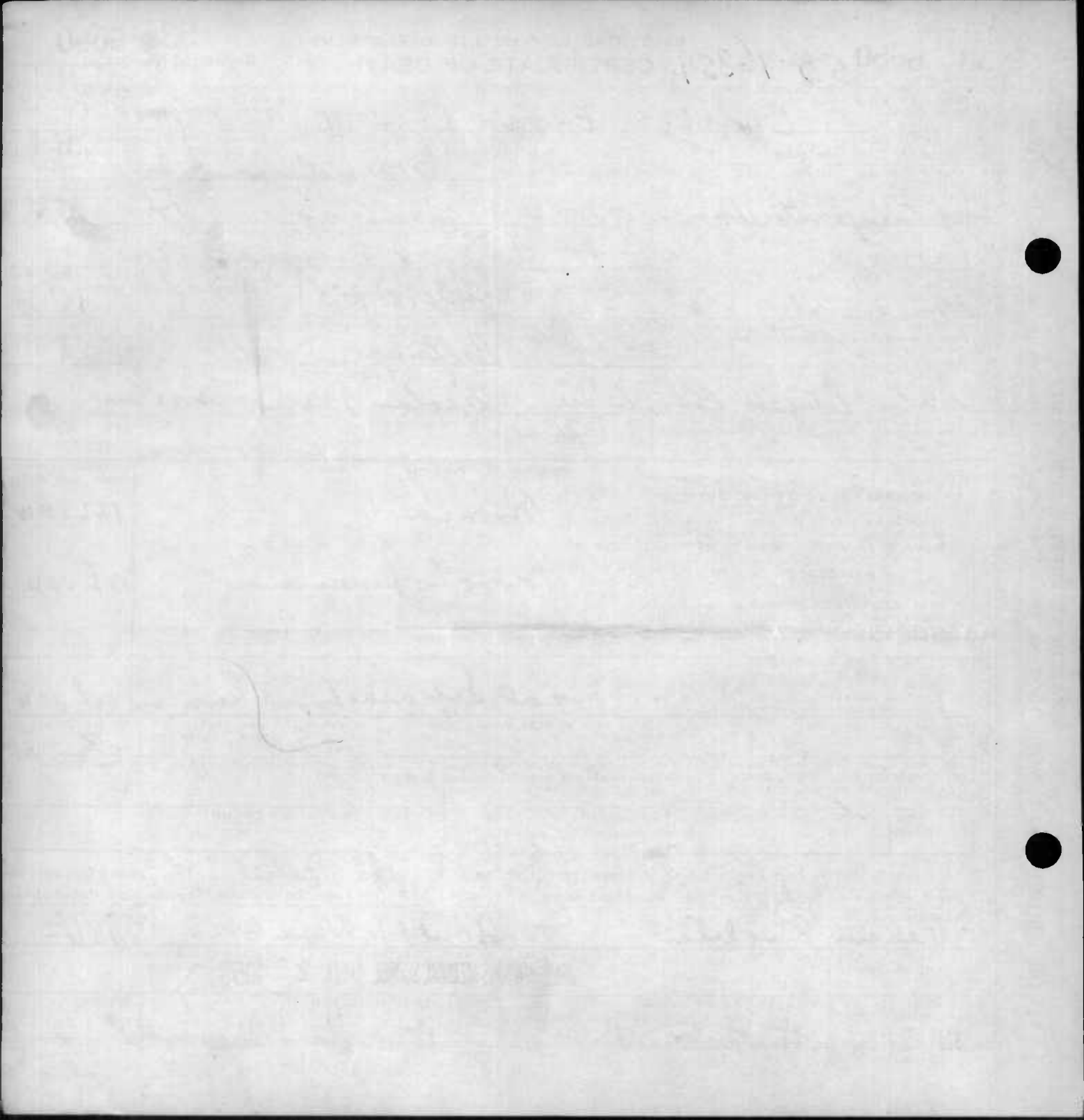
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| BALTIMORE CITY HEALTH DEPARTMENT   |                       |   |  | 53 6680  |   |
|--|-----------------------|---|--|--|---|
| 53 6680 53-16359. CERTIFICATE OF DEATH   |                       |   |  | Registered No.   |   |
| 1. NAME OF DECEASED<br>(Type or Print)   |                       |   | 2. DATE OF DEATH   |  |   |
| Charles Edgar Bond III   |                       |   | July 18 1953   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                       |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 27-06 |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Hospital for the Women of Md  |                       |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 14                               |  |   |
| c. Length of stay in Baltimore   |                       |   | D. STREET ADDRESS (If rural, give location)<br>2308 Evergreen Ave  |  |   |
| 5. SEX<br>M  | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>B  | 8. DATE OF BIRTH<br>July 18 1953   | 9. AGE (In years last birthday)  | 10. Under 1 Year Months: Days   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                       |   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Md.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |
| 13. FATHER'S NAME<br>Charles Edgar Bond Jr.  |                       |   | 14. MOTHER'S MAIDEN NAME<br>Viola Vestes Wallen  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                       |   | 17. INFORMANT ADDRESS  |  |   |
| 16. SOCIAL SECURITY NO.  |                       |   |  |  |   |
| 18. 763.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |                       |   | CAUSE OF DEATH<br>(A) Moxia<br>DUE TO<br>(B) Bone to pneumonia<br>DUE TO<br>(C) 5-15                                       |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                       |   | Interval BETWEEN ONSET AND DEATH<br>12 1/2 104   |  |   |
| 19A. DATE OF OPERATION   |                       |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                       | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from July 18, 1953, to July 18, 1953, that I last saw the deceased alive on July 18, 1953 and that death occurred at 12:35 P.M., from the causes and on the date stated above.   |                       |   |  |  |   |
| 23A. SIGNATURE<br>William Phelant  |                       |   | 23B. ADDRESS<br>H. L. to Women of Md.  |  | 23C. DATE SIGNED<br>7/18/53   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                       | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>JOHN HOPKINS MEDICAL SCHOOL        |   |
|  |                       |   |  | 24D. LOCATION (City, town, or county) (State)<br>JUL 22 1953             |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 28 1953  |                       | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  | 25. FUNERAL DIRECTOR<br>Huntington Williams, M.D.                        |   |



-325

WIDGEON

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6681

TH NO.

NAME OF DECEASED  
(Please Print)

PLACE OF DEATH:

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Length of stay in Baltimore

SEX

USUAL OCCUPATION (Give kind of  
occupation most of working life, even if retired)

FATHER'S NAME

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to July 21, 1953, that I last saw the  
deceased alive on July 20, 1953, and that death occurred at 6:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

1129 N. Caroline St.





-350

3 6682

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6682

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

Nancy

Eaton

2. DATE  
OF  
DEATH

7-23-53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

245 N. Carey St.

Length of stay in Baltimore

7 yrs.

SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

General Pitchford

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

? 1882

9. AGE (In years  
last birthday)

71

11. Under 1 Year  
Months: Days

7 7

12. Under 24 Hours  
Hours: Min.

7 7

11. BIRTHPLACE (State or foreign country)

Littleton, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

unknown

17. INFORMANT

Geo. Eaton - 508 N. Chestnut St.  
Baltimore 23-Md.

18. 442X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1 week

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

m.

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from July 21, 1953 to July 22, 1953 that I last saw the  
deceased alive on July 21, 1953 and that death occurred at 5 P. M., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

Ralph W. Nickling, Jr., D.

426 N. Gibson St.

7/23/53

BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

removal

7-25-53

Pleasant Zion

Littleton, N.C.

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

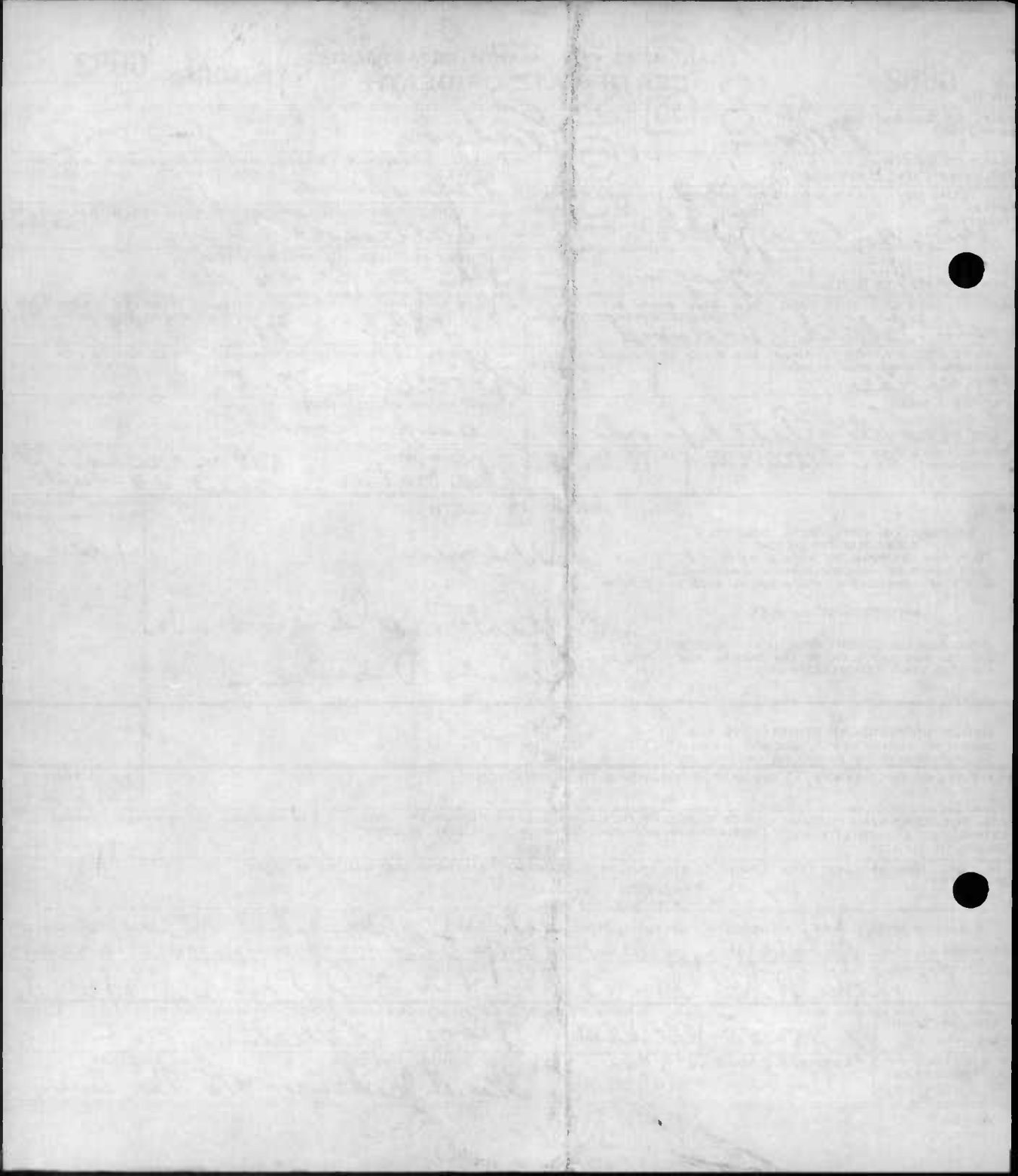
25. FUNERAL DIRECTOR

ADDRESS

JUL 23 1953

Huntington Address

Wm. A. Jackson - 916 Pa. Ave.,



-361  
3 6683

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6683  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

ANNIE L. LAUTERBACH

2. DATE  
OF  
DEATH 7/22/53

PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Lincoln Nursing Home

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

137 E. Birkhead Street

EX 6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6/5/1874

9. AGE (In years last birthday)

79

11 Under 1 Year Months Days

12 Under 24 Hours Hours Min.

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housework

Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

Michael Eagan

14. MOTHER'S MAIDEN NAME

Mary

WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Family - Same

8. 422.1 I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Arterio Sclerotic Changes  
DUE TO Vascular disease  
(B) Chronic Endocarditis

6 mos.  
3 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF DEATH

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 2, 1953, to 7/22, 1953 that I last saw the deceased alive on 7/21, 1953, and that death occurred at 11 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED 7/20/53

24. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county) (State)

Baltimore

25. RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Thurston W. Williams, M.D. James L. McCully - 130 E. Fort Avenue

RAVENSHEIM CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Time of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Place of death: \_\_\_\_\_  
10. Signature of physician: \_\_\_\_\_  
11. Signature of registrar: \_\_\_\_\_  
12. Date of registration: \_\_\_\_\_

CAUSE OF DEATH

13. Signature of physician: \_\_\_\_\_  
14. Signature of registrar: \_\_\_\_\_  
15. Date of registration: \_\_\_\_\_

-600  
53 6684

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6684  
Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle or Print)

MARY JEANNETTE FREY

2. DATE  
OF  
DEATH

July 22, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

St. Joseph's Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

at home

FATHER'S NAME

Donald Disney

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No or unknown

16. SOCIAL  
SECURITY NO.  
none

8. DATE OF BIRTH

Oct. 17, 1895

9. AGE (In years  
last birthday)

57

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Nora Taylor

17. INFORMANT

ADDRESS

Mr. Frederick H. Dugan-1235 Winston Rd.

8. 196X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Sacroma of skull & brain

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from April 30, 1953, to July 22, 1953, that I last saw the deceased alive on July 22, 1953, and that death occurred at 2:20 AM, from the causes and on the date stated above.

23a. SIGNATURE

Wm. J. Liepner

23b. ADDRESS

1400 N. Caroline Street - 13

23c. DATE SIGNED

July 22, 1953

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

7/24/53

24c. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24d. LOCATION (City, town, or county)

Pikesville, Md.

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Liepner

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Liepner & Sons

VS 150

Beth 17, Md.

RECEIVED  
OFFICE OF THE  
ATTORNEY GENERAL

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909  
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS  
1911



MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6685  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH M. PRANKE

2. DATE  
OF  
DEATH

July 22, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1557 Clifton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1557 Clifton Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

May 25, 1894

9. AGE (In years last birthday)

59

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Iceman - Own business

10B. KIND OF BUSINESS OR INDUSTRY

Ice

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frank L. Pranke

14. MOTHER'S MAIDEN NAME

Augusta Sankler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Irene C. Pranke-1557 Clifton Ave.

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

Carcinoma of the lung

6 months

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 9, 1953, to 7/20, 1953, that I last saw the deceased alive on 7/15, 1953, and that death occurred at 7/22/53 m., from the causes and on the date stated above.

23A. SIGNATURE

J. DeLoach

23B. ADDRESS

7122 Northern Rd

23C. DATE SIGNED

7/23/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

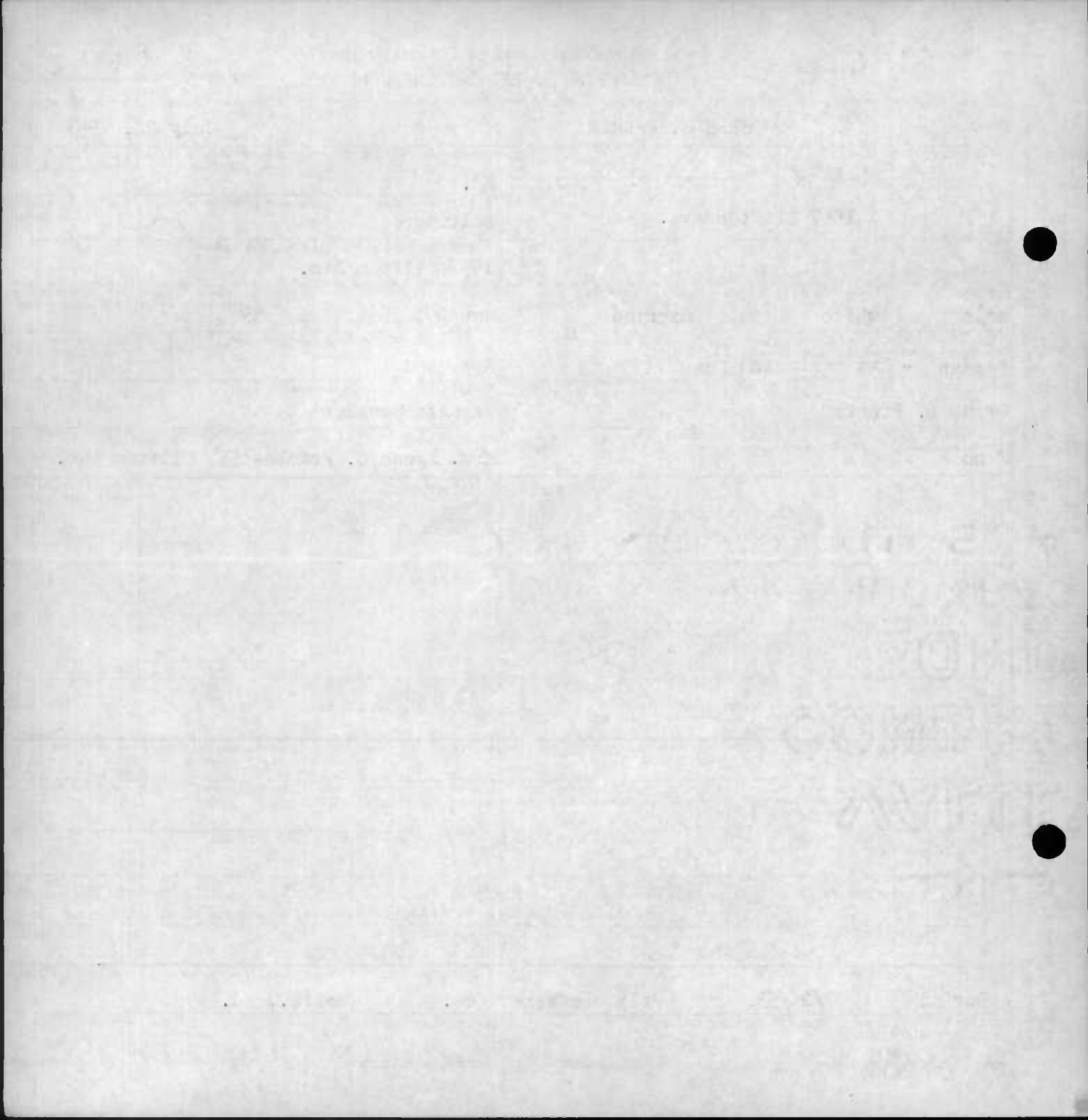
25. FUNERAL DIRECTOR

ADDRESS

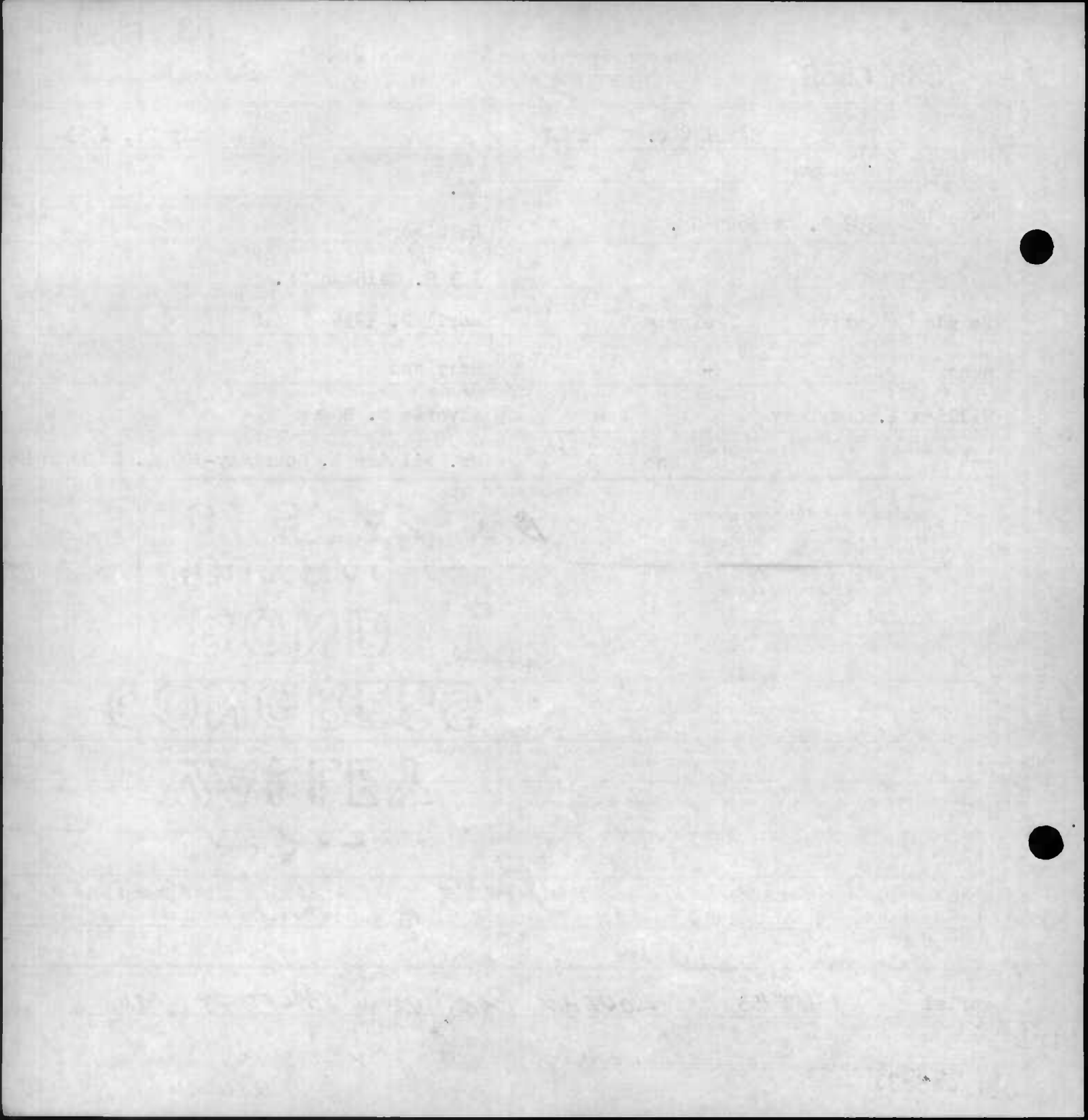
Wm. J. Dickner & Sons  
2906T  
Balto. 17, Md.

JUL 23 1953

VS 150







53 6687

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6687

Registered No.

IRTH NO.

|  |                       |   |                                |
|--|-----------------------|---|--------------------------------|
| NAME OF DECEASED<br>(Type or Print)  |                       | 2. DATE OF DEATH  |                                |
| Mary Elizabeth Dixon   |                       | July 22, 1953   |                                |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |                       | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE<br>Maryland |                                |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>40 S Franklinton Road  |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore                     |                                |
| Length of stay in Baltimore<br>Life  |                       | D. STREET ADDRESS (If rural, give location)<br>40 S. Franklinton Road   |                                |
| SEX<br>F   | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>W  | 8. DATE OF BIRTH<br>12/23/1862 |
| 9. AGE (In years last birthday)<br>90  |                       | 10. Under 1 Year<br>Months: Days: Hours: Min.   |                                |
| A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House wife  |                       | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home   |                                |
| FATHER'S NAME<br>Notley T. Bateman   |                       | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                                |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA  |                       | 14. MOTHER'S MAIDEN NAME<br>Caroline Jackson  |                                |
| 17. INFORMANT<br>Miss Pearl Dixon  |                       | ADDRESS<br>40 S. Franklinton  |                                |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Cerebral Thrombosis<br>DUE TO<br>Arteriosclerotic - cardio vascular disease<br>DUE TO<br>rascular disease<br>DUE TO |                       | INTERVAL BETWEEN ONSET AND DEATH<br>1 wk.<br>8 yrs  |                                |
| 19. DATE OF OPERATION<br>0   |                       |   |                                |
| 19B. MAJOR FINDINGS OF OPERATION   |                       |   |                                |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                       |   |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                       | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                     |                                |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                       |   |                                |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                       | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |                                |
| 21F. HOW DID INJURY OCCUR?   |                       |   |                                |
| 22. I hereby certify that I attended the deceased from 1943, 19, to July 22, 1953, that I last saw the deceased alive on July 22, 1953, and that death occurred at 3 P. M., from the causes and on the date stated above.  |                       |   |                                |
| 23A. SIGNATURE<br>Robert T. Todd   |                       | 23B. ADDRESS<br>2108 St Paul St.  |                                |
| 23C. DATE SIGNED<br>7/23/53  |                       |   |                                |
| A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                       | 24B. DATE<br>7/25/53  |                                |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Louden Park  |                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.  |                                |
| 25. FUNERAL DIRECTOR<br>John T. Stansbury  |                       | ADDRESS<br>2700 Edmondson Ave.  |                                |

12.30 - 2



M-250  
53 6688BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6688  
Registered No.

IRTH NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| NAME OF DECEASED<br>(Type or Print)   |  | Mary Mc Shane   |  | 2. DATE<br>OF<br>DEATH   |  | July 21, 1953  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)          |  |  |  |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>Colonial Nursing Home  |  |   |  | A. STATE<br>Md.  |  | B. COUNTY<br>Balto.  |  |
| Length of stay in Baltimore   |  |   |  | C. CITY OR TOWN<br>(If outside corporate limits, write RURAL and give township)<br>Catonsville |  |  |  |
| SEX<br>F  |  |   |  | D. STREET ADDRESS (If rural, give location)<br>305 n. Beechwood Ave.                           |  | 5352   |  |
| 6. COLOR OR RACE<br>W   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single   |  | 8. DATE OF BIRTH<br>Sept. 1863   |  | 9. AGE (In years last birthday)<br>89                                    |  |
| 10a. KIND OF BUSINESS OR INDUSTRY<br>Housekeeper Ret.   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Private Home   |  | 11. BIRTHPLACE (State or foreign country)<br>Ireland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>England                                  |  |
| FATHER'S NAME<br>John Mc Shane  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Jane Mc Cann   |  |  |  |
| WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>----   |  | 17. INFORMANT<br>Miss Anne Walsh 305 N. Beechwood Ave.   |  |  |  |
| 18. 420.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CORONARY THROMBOSIS<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>CARDIO. VASCULAR RENAL DIS.<br>NEPHRITIS<br>CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>3 yrs?<br>1 yr. |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br>0   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                    |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from 2. 28, 1949 to 7. 21, 1953, that I last saw the deceased alive on 7. 20, 1953, and that death occurred at 2:15 A.M., from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br>George E Urban  |  | 23B. ADDRESS<br>805 2nd Ave. 28md   |  | 23C. DATE SIGNED<br>7. 21. 53  |  |  |  |
| 24A. DATE<br>7-23-53  |  | 24B. NAME OF CEMETERY OR CREMATORY<br>Holy Sepulchre Cem.   |  | 24C. LOCATION (City, town, or county) (State)<br>New Rochelle New York                         |  |  |  |
| 24D. DATE RECEIVED BY<br>23 1953  |  | 24E. REGISTRAR'S SIGNATURE<br>Huntington  |  | 24F. FUNERAL DIRECTOR<br>George A. Farley Catonsville, Md.                                     |  |  |  |



W-420  
53 6689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6689  
Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print) **JOHN R. WALLIS** 2. DATE OF DEATH **7/20/53**

PLACE OF DEATH: **Baltimore City, Maryland** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MD.** B. COUNTY

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION **228 E. LOMBARD ST.** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**BALTIMORE 26-10**

Length of stay in Baltimore **LIFE** D. STREET ADDRESS (If rural, give location)  
**3238 E. LOMBARD ST.**

SEX **M** 6. COLOR OR RACE **W** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH **1/25/1882** 9. AGE (In years last birthday) **71** If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) **STIMULATOR** 10b. KIND OF BUSINESS OR INDUSTRY **SHEET METAL** 11. BIRTHPLACE (State or foreign country) **MD.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

FATHER'S NAME **ROBERT WALLIS** 14. MOTHER'S MAIDEN NAME **MARY WACKER**

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **NO** 17. INFORMANT **ROBERT WALLIS** ADDRESS **407 N. HIGHLAND AVE.**

18. **420.1** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cronary Occlusion**  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Cronary arteriosclerosis**  
DUE TO  
(C) **arteriosclerosis**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-1-1954** to **7-20-1953**, that I last saw the deceased alive on **7-20-1953**, and that death occurred at **11:20 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE **John J. Gault** M. D. 23B. ADDRESS **14 N. Egleston - 2x** 23C. DATE SIGNED **7-21-53**

A. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **7/24/1953** 24C. NAME OF CEMETERY OR CREMATORY **PARKWOOD** 24D. LOCATION (City, town, or county) (State) **BALTO. MD.**

25. FUNERAL DIRECTOR **Clarence F. Hoffmann** ADDRESS **1639 N. BROADWAY**

VS. 150. **099 24**

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

S-540  
53 6690

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6690  
Registered No.

|  |                               |   |  |   |   |
|--|-------------------------------|---|--|---|---|
| RTH NO.  |                               | NAME OF DECEASED<br>(Type or Print) <b>Small, E. Winifred.</b>  |  | 2. DATE OF DEATH<br><b>7/20/53</b>  |   |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland.</b><br>B. COUNTY |  |   |   |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>FRANKLIN SQUARE Hosp.</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b>                                |  |   |   |
| Length of stay in Baltimore<br>Yrs. Mos. Days  |                               | D. STREET ADDRESS (If rural, give location)<br><b>20 E. Carey ST.</b>   |  |   |   |
| SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>   | 8. DATE OF BIRTH<br><b>July 13, 1884</b> | 9. AGE (In years, last birthday)<br><b>69</b>                                       | If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min. |
| A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)<br><b>H. W.</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>                       |   |
| FATHER'S NAME<br><b>Joseph Madigan</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>- Ann. Farrell.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no or unknown</b>  |                               | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>- Irene Benson - 20 E. Carey ST.</b>                    |   |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hyp. c. v. disease.</b>                                  |                               | CAUSE OF DEATH<br>(A) DUE TO  |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Coronary insufficiency</b>  |                               | (B) DUE TO  |  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                               | (C)   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                               | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>                          |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>7/20</b> , 19 <b>53</b> , to <b>7-20</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>53</b> , and that death occurred at <b>11:55 pm.</b> , from the causes and on the date stated above. |                               |   |  |   |   |
| 23A. SIGNATURE<br><b>Shehuell</b>  |                               | 23B. ADDRESS<br><b>Franklin Square Hospital</b>   |  | 23C. DATE SIGNED<br><b>7/21/53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                               | 24B. DATE<br><b>7/24/53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>                          |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md</b>  |                               | 25. FUNERAL DIRECTOR<br><b>Watt &amp; B. M. Walters</b>   |  | ADDRESS<br><b>1844 &amp; Ostricker Sts</b>  |   |

0013

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

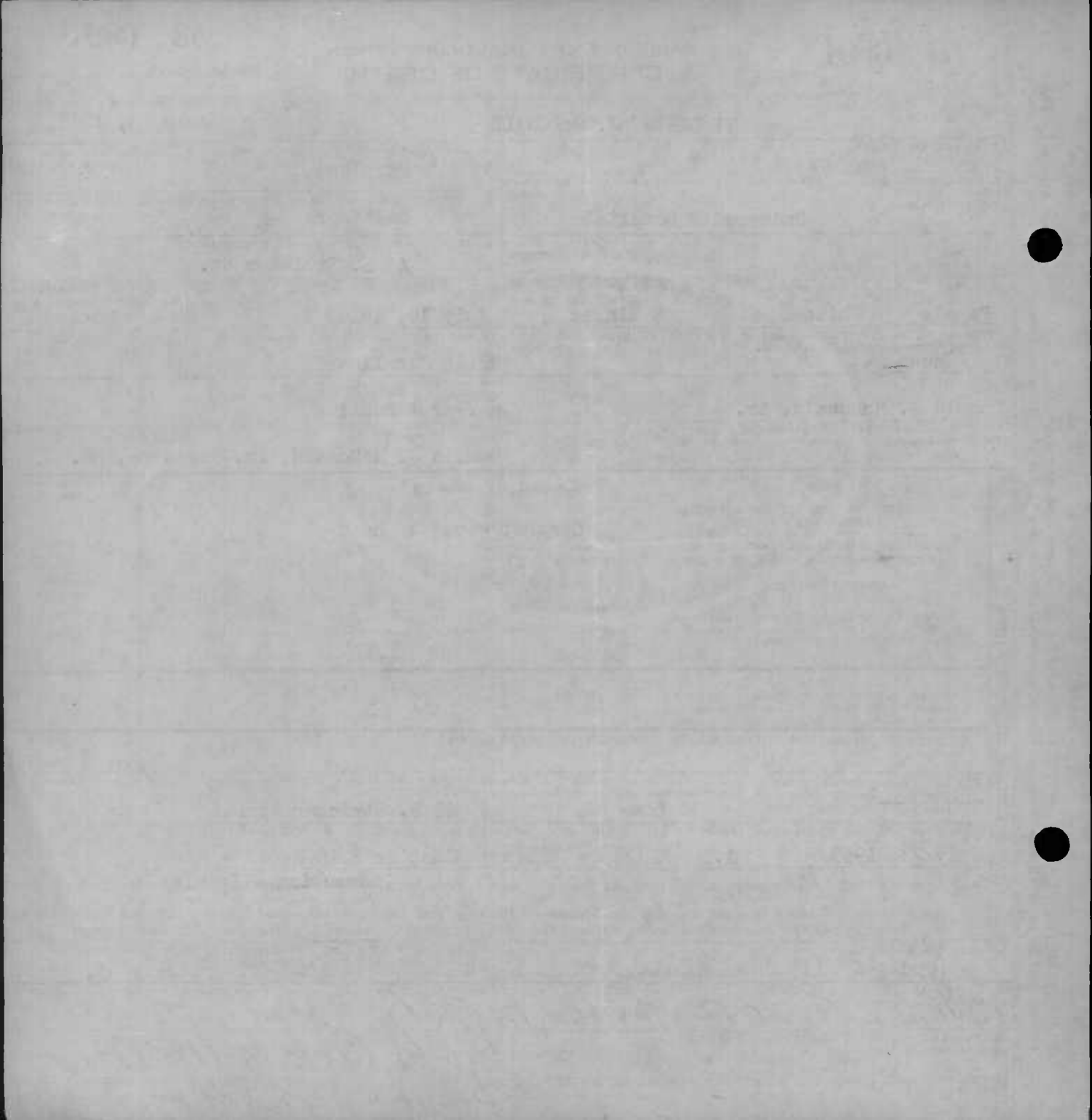
53 6691

Registered No. \_\_\_\_\_

|   |   |
|---|---|
| BIRTH NO. <span style="float:right">M-235<br/>53 6691</span>  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="float:right">VIRGINIA J. McDONALD</span>  |   |
| 2. DATE OF DEATH <span style="float:right">July 23, 1953</span>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <span style="float:right">not in hospital or institution, give street address or location)</span><br><span style="float:right">University Hospital</span> |   |
| C. LENGTH OF STAY IN BALTIMORE <span style="float:right">27 Yrs. Mos. Days</span>   |   |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="float:right">Maryland</span> B. COUNTY   |   |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><span style="float:right">Baltimore 19-03</span>  |   |
| D. STREET ADDRESS (If rural, give location)<br><span style="float:right">43 S. Stricker St.</span>  |   |
| 5. SEX <span style="float:right">Female</span>  | 6. COLOR OR RACE <span style="float:right">White</span> |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <span style="float:right">Single</span>   |   |
| 8. DATE OF BIRTH <span style="float:right">July 10, 1916</span>   |   |
| 9. AGE (In years last birthday) <span style="float:right">37</span>   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float:right">none</span>   |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country) <span style="float:right">North Carolina</span>   |   |
| 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME <span style="float:right">Donald J. McDonald, Sr.</span>  |   |
| 14. MOTHER'S MAIDEN NAME <span style="float:right">Margaret Bunting</span>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <span style="float:right">Donald J. McDonald, Jr.--Pasadena, Md.</span>   |   |
| ADDRESS   |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <span style="font-size: 1.5em;">E976x</span> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><span style="float:right">(A) Gunshot wound of head</span> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br><span style="float:right">(B)</span>   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><span style="float:right">(C)</span>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><span style="float:right">home</span>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><span style="float:right">43 S. Stricker Street</span> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><span style="float:right">July 23, 1953 A. m.</span>   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><span style="float:right">Shot self in head</span>   |  |
| 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Joseph A. Jachimczyk</span> M.D.  |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><span style="float:right">July 23, 1953</span>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  |  | 24B. DATE<br><span style="font-size: 1.2em;">7-25-53</span>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">RODON PARK</span>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">BALTO Md</span>  |  | 24E. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Hoff &amp; B. M. Walters</span>   |  | 24F. ADDRESS<br><span style="font-size: 1.2em;">PRA H &amp; STRICKER STS</span>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE<br><span style="font-size: 1.2em;">Huntington</span>   |  | 25. FUNERAL DIRECTOR   |  |



H-450  
53 6692BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6692  
Registered No.

|  |  |                                |  |   |  |   |  |  |  |
|--|--|--------------------------------|--|---|--|---|--|--|--|
| BIRTH NO.  |  |                                | 1. NAME OF DECEASED<br>(Type or Print) <i>Ernie Mae Hillen</i> |   |  | 2. DATE OF DEATH<br><i>7/15/53</i>  |  |  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <i>2101 W. Calhoun</i>                                   |  |                                |  |   |  | b. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>STATE <i>MD</i> COUNTY <i>Montgomery</i> |  |  |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Bm Wal Tra Home</i>  |  |                                |  |   |  | c. CITY OR TOWN<br><i>Mt. Airy</i>  |  |  |  |
| e. Length of stay in Baltimore<br><i>62</i>  |  |                                |  |   |  | d. STREET ADDRESS (If rural, give location)<br><i>2101 Cold Spring Lane</i>   |  |  |  |
| 5. SEX<br><i>Female</i>  |  | 6. COLOR OR RACE<br><i>Cal</i> |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i> |  | 8. DATE OF BIRTH<br><i>Oct 17-1890</i>  |  | 9. AGE (In years last birthday) Months Days<br><i>62</i>           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>maid</i> |  |                                |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Dom. family</i>           |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><i>North Carolina</i> |  |
| 13. FATHER'S NAME<br><i>Ernie Hillen</i>   |  |                                |  | 14. MOTHER'S MAIDEN NAME<br><i>Melba Bellingsley</i>              |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                         |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>           |  |                                |  | 16. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT<br><i>Mr. Marshall</i>                               |  |
|  |  |                                |  | ADDRESS   |  |   |  |  |  |

|  |  |   |  |                                  |  |
|--|--|---|--|----------------------------------|--|
| 18. <i>442X</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH<br><i>2543 M. C. Calhoun</i> |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) DUE TO<br><i>Cardio Vascular Renal</i>   |  |   |  |                                  |  |
| (B) DUE TO<br><i>Acute Hypertension</i>  |  |   |  | <i>3 years</i>                   |  |
| (C) DUE TO   |  |   |  |                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |  |                                  |  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21d. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>7/15/53</i> , to <i>7/15/53</i> , that I last saw the deceased alive on <i>7/15/53</i> and that death occurred at <i>11:55</i> a. m., from the causes and on the date stated above. |  |   |  |  |  |
| 23a. SIGNATURE<br><i>Dr. Jackson</i>  |  | 23b. ADDRESS<br><i>1000 Calhoun</i>   |  | 23c. DATE SIGNED<br><i>7/15/53</i>                                       |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24b. DATE<br><i>July 22, 1953</i>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn</i>                  |  |
| 24d. LOCATION (City, town, or county)<br><i>Baltimore, Md.</i>  |  | 24e. FUNERAL DIRECTOR<br><i>Stallard Funeral Home</i>   |  | 24f. ADDRESS<br><i>1631 David Hill Ave</i>                               |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>23 1953</i>  |  | REGISTRAR'S SIGNATURE<br><i>Huntington</i>  |  | 25. FUNERAL DIRECTOR<br><i>Stallard</i>                                  |  |



P-200  
53 6693

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6693

Registered No.

BIRTH NO.

|   |   |   |  |
|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>REV. A. DOCTOR GEORGE RICHARD PAGE</b>  |   | 2. DATE OF DEATH <b>JULY 21, 1953</b>   |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>FRANKLIN SQUARE HOSP.</b> |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 13-03</b>                      |  |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>251 P Francis St</b>   |   | D. STREET ADDRESS (If rural, give location)   |  |
| 7. SEX<br><b>M</b>  | 8. COLOR OR RACE<br><b>NEGRO</b>  | 9. SINGLE (MARRIED)<br><b>WIDOWED, DIVORCED (Specify)</b>   | 10. DATE OF BIRTH<br><b>Aug 10, 1885</b> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>CLERGYMAN</b>               | 12. PLACE OF BIRTH (State or foreign country)<br><b>Gloucester Co. Va</b> | 13. CITIZENSHIP (What country?)<br><b>U. S. A.</b>  |  |
| 14. FATHER'S NAME<br><b>Edward Page</b>   |   | 15. MOTHER'S MAIDEN NAME<br><b>Caroline Bolden</b>  |  |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)  |   | 17. SOCIAL SECURITY NO.<br><b>Mr. Matthew Page</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary edema</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO   |  |                                  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 21A. DATE OF OPERATION   |  | 21B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-7-53</b> , 1953, to <b>7-21-53</b> , 1953, that I last saw the deceased alive on <b>7-21-53</b> , 1953, and that death occurred at <b>3:10 Pm.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>William L. Harrison</b>   |  | 23B. ADDRESS<br><b>Franklin Sq. Hosp.</b>   |  | 23C. DATE SIGNED<br><b>July 21, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><b>July 26, 1953</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul</b>                               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Gloucester Co. Va</b>  |  | 24E. FUNERAL DIRECTOR<br><b>Wallace Funeral Home</b>  |  | 24F. ADDRESS<br><b>1631 Smith Hill Ave</b>  |  |

009FW

1950

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1950

1. Name of Deceased

2. Sex

3. Date of Birth

4. Date of Death

5. Place of Birth

6. Usual Residence

7. Cause of Death

8. Manner of Death

9. Signature of Physician

10. Signature of Registrar

11. Signature of Coroner

12. Signature of Medical Examiner

13. Signature of Burial Officer

14. Signature of Funeral Home

15. Signature of Cemetery

16. Signature of Undertaker

17. Signature of Burial Officer

18. Signature of Funeral Home

19. Signature of Cemetery

20. Signature of Undertaker

21. Signature of Burial Officer

22. Signature of Funeral Home

23. Signature of Cemetery

24. Signature of Undertaker

25. Signature of Burial Officer

26. Signature of Funeral Home

27. Signature of Cemetery

28. Signature of Undertaker

29. Signature of Burial Officer

30. Signature of Funeral Home



53 6694

BALTIMORE CITY HEALTH DEPARTMENT

53 6694

Registered No.

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution, residence

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

O. STREET ADDRESS (If rural, give location)

1606 N. Chesapeake St

C. Length of stay in Baltimore

3 yrs.

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

9-28-49

9. AGE (In years last birthday)

3

10. Under 1 Year

Months

11. Under 24 Hours

Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

home

10B. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Virginia Green

13. FATHER'S NAME

James Hutchinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

Yes, no or unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 756.2

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Bleeding Cerebrum

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Congenital Atheria of

(C)

Bile ducts.

INTERVAL BETWEEN ONSET AND DEATH

since Birth.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/6 1953 to 7-20, 1953, that I last saw the deceased alive on 7-20, 1953, and that death occurred at 8:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Huntington W. Harrison, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/20/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Holladay Funeral Home

Huntington W. Harrison, M.D.

1631 Swift Hill Ave.

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6695

Registered No. \_\_\_\_\_

BIRTH NO

1. NAME OF DECEASED  
(Type or Print)

WILLIAM N. BLACKWELL

2. DATE OF DEATH July 21, 1953

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (not in hospital or institution, give street address or location)

University Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Aug. 19, 1896

9. AGE (In years last birthday)

56

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Uriah Blackwell

14. MOTHER'S MAIDEN NAME

Sally Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Sarah A. Thompson 627 W. Mosher St.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Terminal bronchopneumonia

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimszyk

M.D.

23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....

23C. DATE SIGNED July 21, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial July 25, 1953 Mt. Auburn Baltimore, Md.

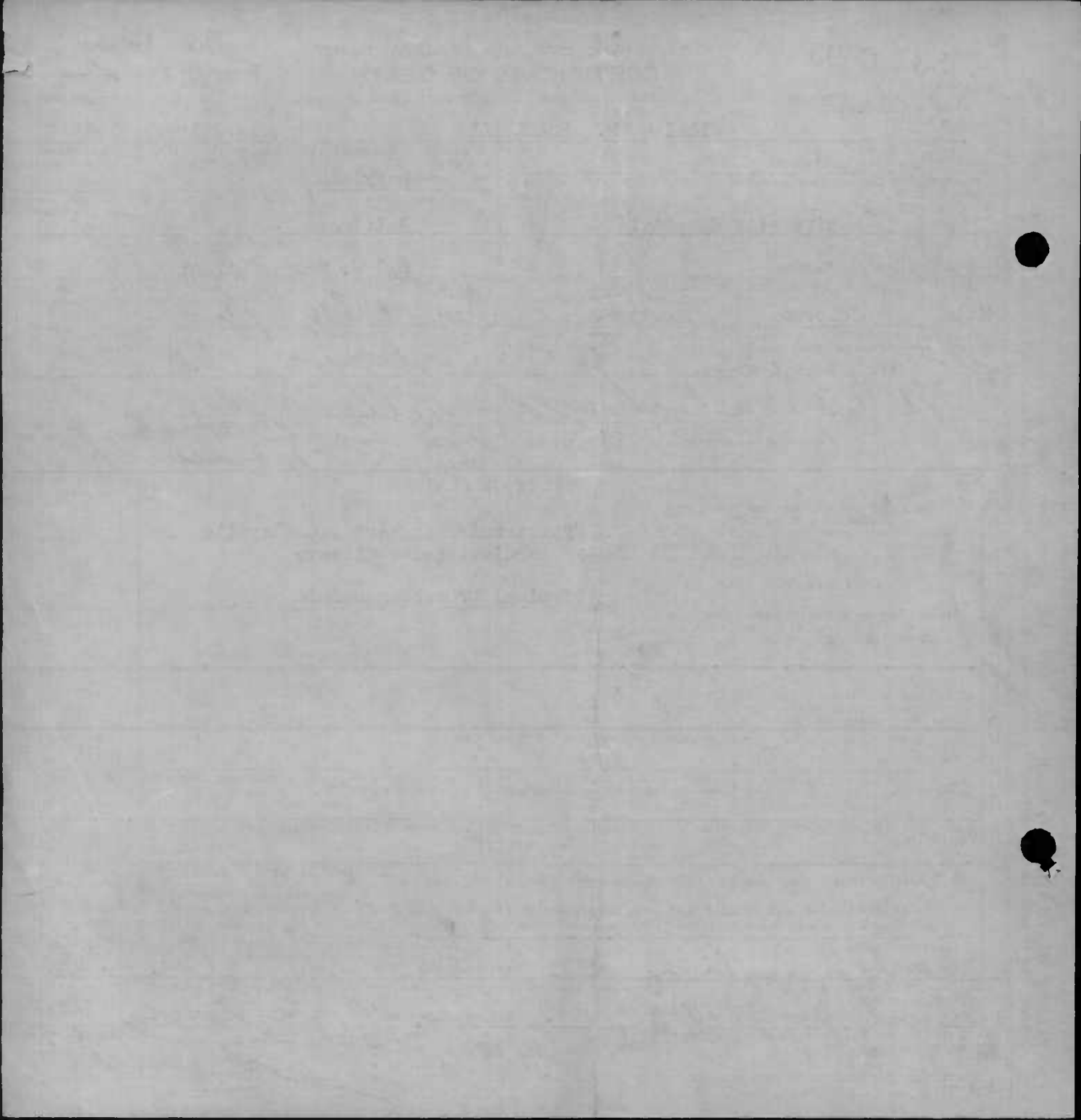
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Funeral Home 1631 Druid Hill Ave.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-120

53 6696

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6696  
Registered No.

BIRTH NO.

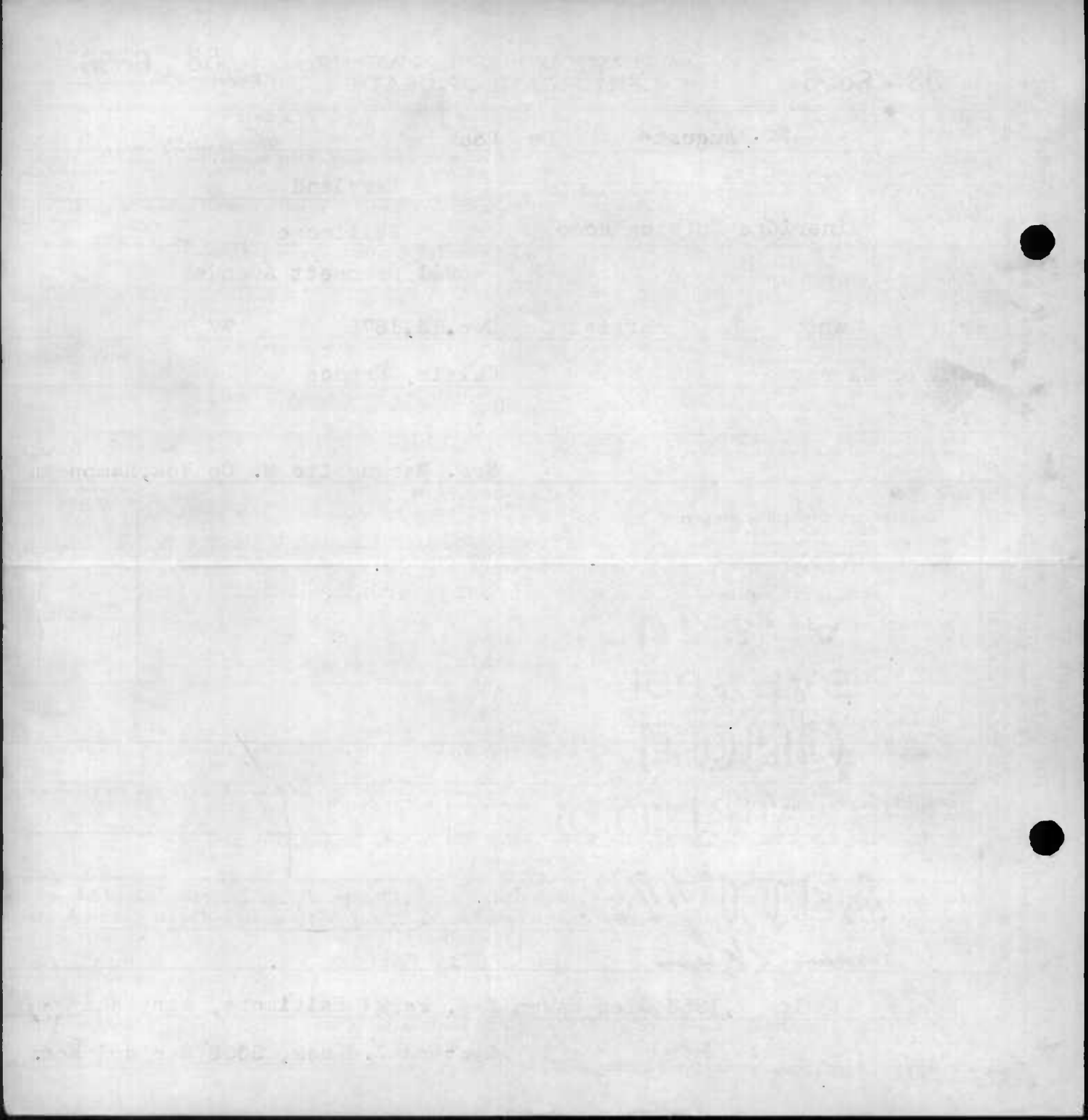
|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Mr. Auguste De Vos</b>  |                                  | 2. DATE OF DEATH<br><b>July 22, 1953</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>60 Pineridge Nursing Home</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-03</b>                         |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5201 Hampnett Avenue</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>  | 8. DATE OF BIRTH<br><b>Dec. 13, 1875</b>      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clergy</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years, last birthday)<br><b>77</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Calais, France</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>?</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)             |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mrs. Marguerite M. De Vos, Hampnett</b>  |                                  | ADDRESS <b>5201</b>  |   |

|  |  |   |
|--|--|---|
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic heart disease with failure.</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Chronic coronary insufficiency</b>  |  | <b>6 months</b>                                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |

|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **Jan.**, 1953, to **July 22**, 1953, that I last saw the deceased alive on **July 14**, 1953, and that death occurred at **4 a.m.**, from the causes and on the date stated above.

|   |   |   |
|---|---|---|
| 23A. SIGNATURE<br><b>James E. White</b>                             | 23B. ADDRESS<br><b>5814 Harford Rd.</b> | 23C. DATE SIGNED<br><b>July 22/53</b>                             |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>          | 24B. DATE<br><b>July 1953</b>           | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b> |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore, Maryland</b> |   | 25. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, 5305 Harford Road</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 23 1953</b>             |   | REGISTRAR'S SIGNATURE<br><b>Huntington</b>                        |





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

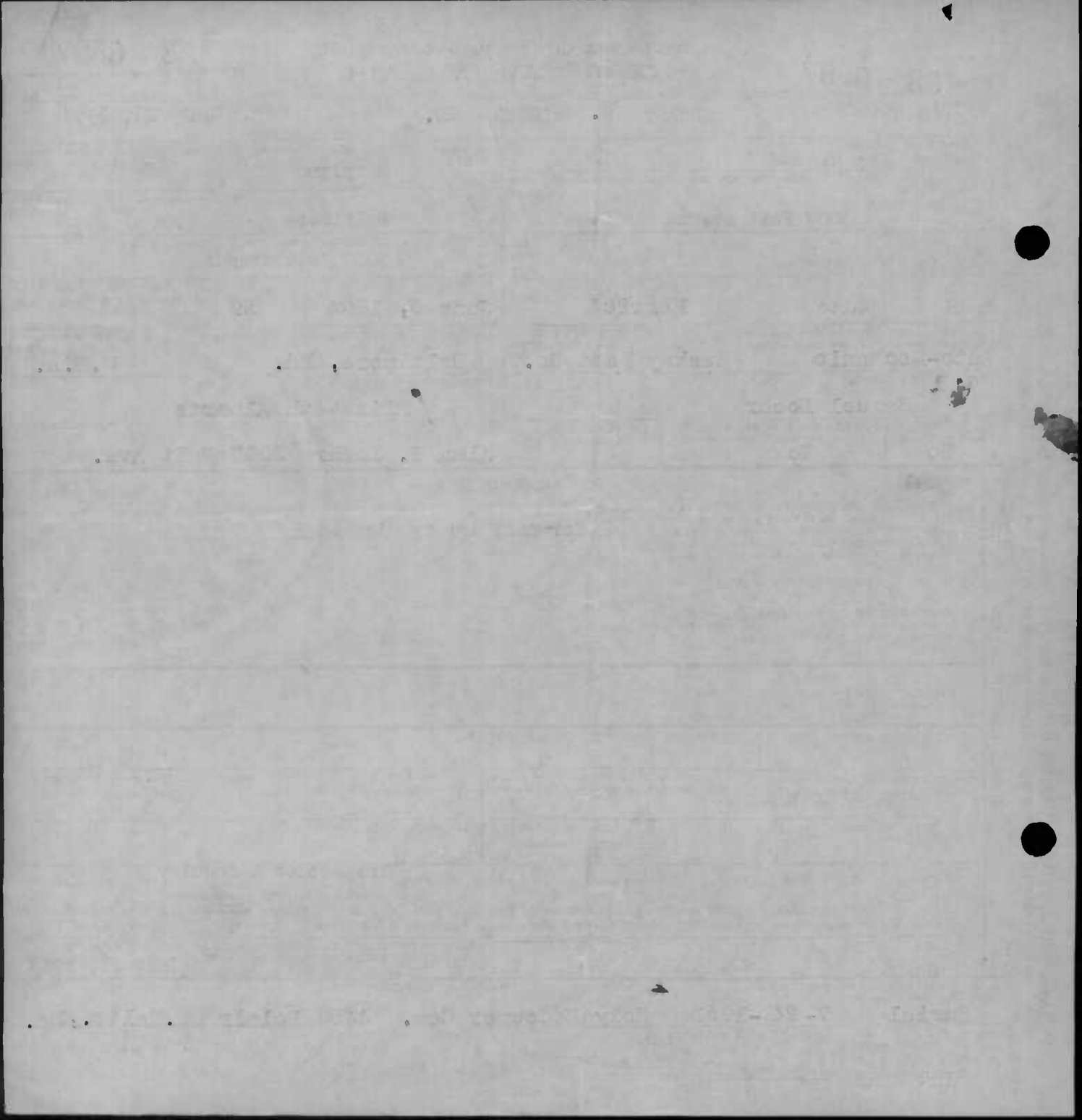
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 6697**

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH <b>53 6697</b>   |  | ERNEST W. LOEHR SR.  |  | 2. DATE OF DEATH<br><b>July 21, 1953</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print)                             |  |  |  | 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3007 Fait Avenue</b> |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY   |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days                   |  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 8. DATE OF BIRTH<br><b>June 5, 1894</b>   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  |  | 9. AGE (In years last birthday)<br><b>59</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auto-Mechanic</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Samuel Loehr</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Alberts</b>               |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Alma I. Loehr</b>                              |  | ADDRESS<br><b>3007 Fait Ave.</b>   |  | 18. 420.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Coronary artery disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO<br><b>(C)</b> |  |

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 19A. DATE OF OPERATION   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |   |  | 21E. INJURY OCCURRED<br>M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>inspection &amp; inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b>  |  |   |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  |   |  | 23C. DATE SIGNED<br><b>July 21, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>7-24-1953</b>                       |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>4430 Belair Rd. Balto., Md.</b> |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>23 1953</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>Charles S. Geiler</b>  |  | ADDRESS<br><b>901 S. CONKLING ST. BALTO., MD.</b>                                   |  |   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

53 6698  
 Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
 (Type or Print)

*Baby Girl Harding*

2. DATE  
 OF  
 DEATH

*7-21-53*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
 HOSPITAL OR INSTITUTE

*Provident Hospital*

C. Length of stay in Baltimore

*4*

5. SEX

*Female*

6. COLOR OR RACE

*Negro*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Single*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Infant*

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

*John Harding*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
 A. STATE B. COUNTY

*Md.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto.*

D. STREET ADDRESS (If rural, give location)

*1411 Dennis Hill Ave*

8. DATE OF BIRTH

*July 18, 1953*

9. AGE (In years last birthday)

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

14. MOTHER'S MAIDEN NAME

*Lillian*

17. INFORMANT

*John Harding*

ADDRESS

*1411 Dennis Hill Ave*

1B. *776x*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Prematurity*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*3-13*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 18, 1953*, to *July 21, 1953* that I last saw the deceased alive on *July 21, 1953*, and that death occurred at *5:40 p. m.*, from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS,

*Provident Hospital*

23C. DATE SIGNED

*7-22-53*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*7/23/53*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Auburn Cem*

24D. LOCATION (City, town, or county) (State)

*Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*[Signature]*

25. FUNERAL DIRECTOR

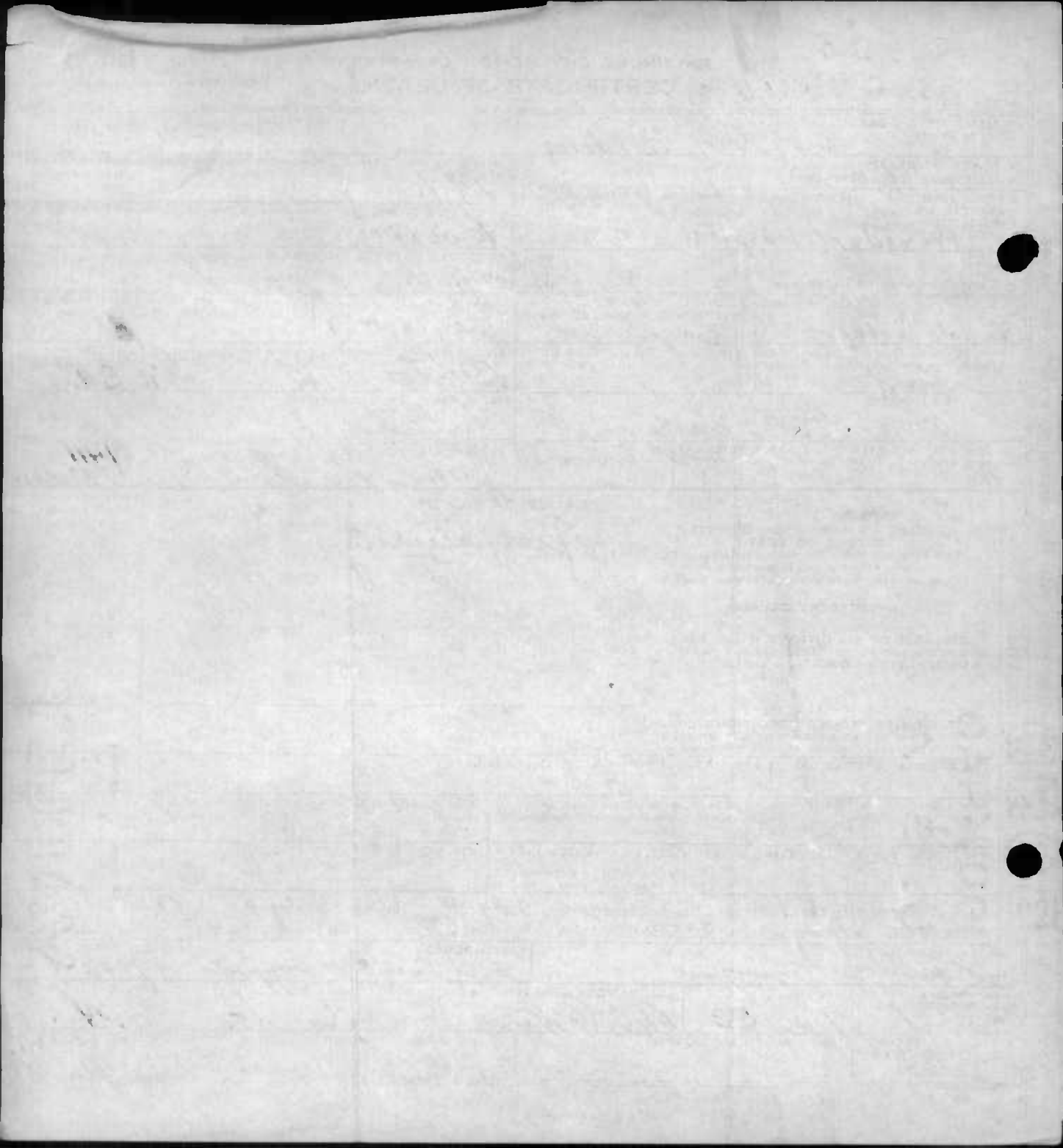
*Mrs. Kate R. Williams*

ADDRESS

*322 N. Schaefer St.*

*Huntington Williams, M.D.*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

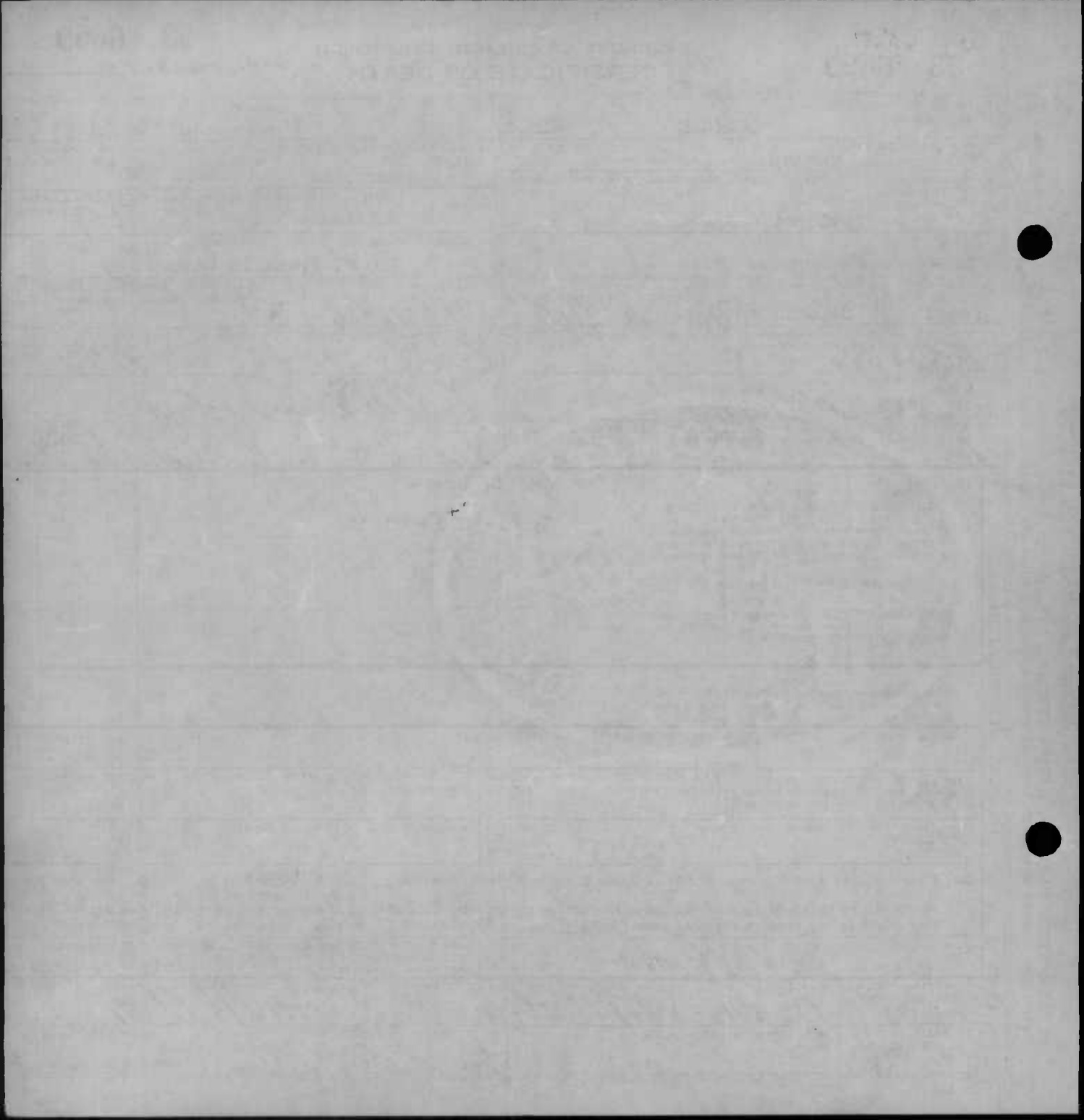
W-536  
53 6689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6689

Registered No.

|  |                             |   |  |  |                                       |
|--|-----------------------------|---|--|--|---------------------------------------|
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE OF DEATH   |                                       |
|  |                             | LUCILLE WINDER  |  | July 22, 1953  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Provident Hospital  |                             |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 17-03            |                                       |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                             |   |  | D. STREET ADDRESS (If rural, give location)<br>710 W. Franklin Street                                      |                                       |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married (Sep.)   |  | 8. DATE OF BIRTH<br>12/29/1918   | 9. AGE (In years last birthday)<br>34 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md.  |                                       |
| 13. FATHER'S NAME<br>George Williams   |                             | 14. MOTHER'S MAIDEN NAME<br>Idella Woodson  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>No   |                             | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Geo. H. Wms. Enclis St. W. Wash.  |                                       |
| 18. 023X   |                             | CAUSE OF DEATH  |  |  |                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                             | (A) Syphilitic aortitis   |  |  |                                       |
| ANTECEDENT CAUSES  |                             | (B)   |  |  |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                             | DUE TO  |  |  |                                       |
| OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                             | (C)   |  |  |                                       |
| 19A. DATE OF OPERATION   |                             | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                                       |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                   |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                             | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>       |  | 21F. HOW DID INJURY OCCUR?   |                                       |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                             |   |  |  |                                       |
| 23A. SIGNATURE<br>J. B. Fisher   |                             | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR |  | 23C. DATE SIGNED<br>July 22, 1953  |                                       |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify)<br>Burial  |                             | 24B. DATE<br>7/25/1953  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.   |                                       |
| 24D. LOCATION (City, town, or county)<br>Cedar Hill Md.  |                             | 24E. FUNERAL DIRECTOR<br>Miss Marie R. Williams   |  | 24F. ADDRESS<br>322 N. Schroeder St.   |                                       |





53

52-23689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6700  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)10 Under 1 Year  
Months; Days11 Under 24 Hours  
Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/20 1953, to 7/21 1953 that I last saw the deceased alive on 7/20 1953, and that death occurred at 6:45 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

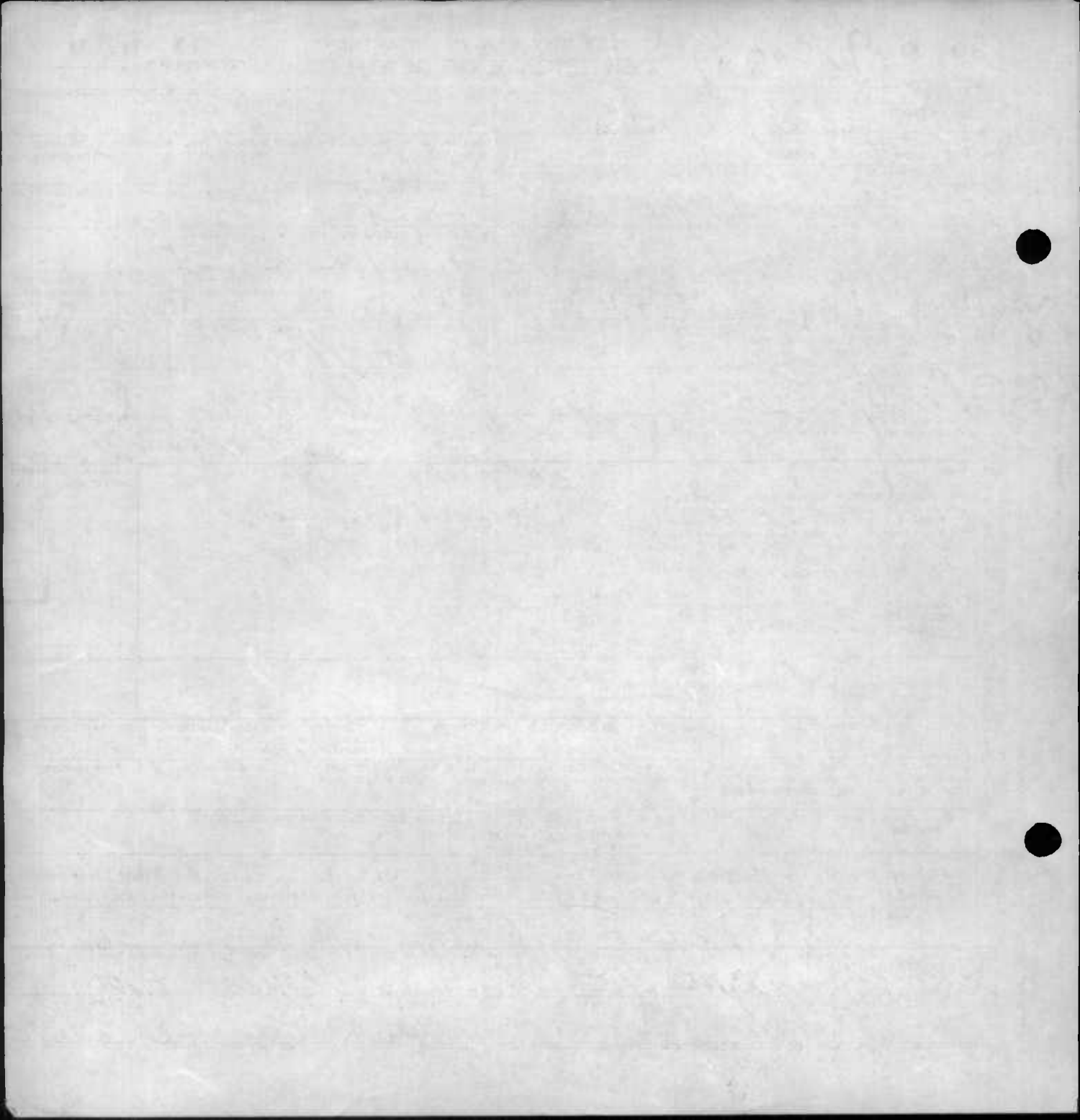
25. FUNERAL DIRECTOR

ADDRESS

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



AB-157777 P-525  
53 16701

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6701  
Registered No.

BIRTH NO.

|  |                                 |   |  |
|--|---------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Talmage D. Pinkney</b>   |                                 | 2. DATE OF DEATH <b>July 21-1953</b>  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b><br><b>31 4940 Eastern Ave.</b> |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 16-04</b>            |  |
| c. Length of stay in Baltimore <b>Life</b>   |                                 | D. STREET ADDRESS (If rural, give location)<br><b>1010 N. Payson St. zone 17</b>                                  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>Col.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>Oct. 9- 1880</b>      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Butler</b>   |                                 | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>72</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                 | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>?</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Esther Pinkney</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                 | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Baltimore City Hospitals</b>   |                                 | ADDRESS<br><b>Records: 4940 Eastern Ave.</b>  |  |

|   |                                  |
|---|----------------------------------|
| 18. <b>446x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>P Neumonia</b><br>DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriolar Nephrosclerosis</b><br>DUE TO   |                                  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><b>7-21-1953</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from **3-25-1952**, to **7-21-1953**, that I last saw the deceased alive on **7-21-1953**, and that death occurred at **1.50A** m., from the causes and on the date stated above.

|                                      |  |   |
|--------------------------------------|--|---|
| 23A. SIGNATURE<br><b>H. John Doe</b> | 23B. ADDRESS<br><b>M. O. 4940 Eastern Ave., Baltimore, Md.</b> | 23C. DATE SIGNED<br><b>July 21-1953</b> |
|--------------------------------------|--|---|

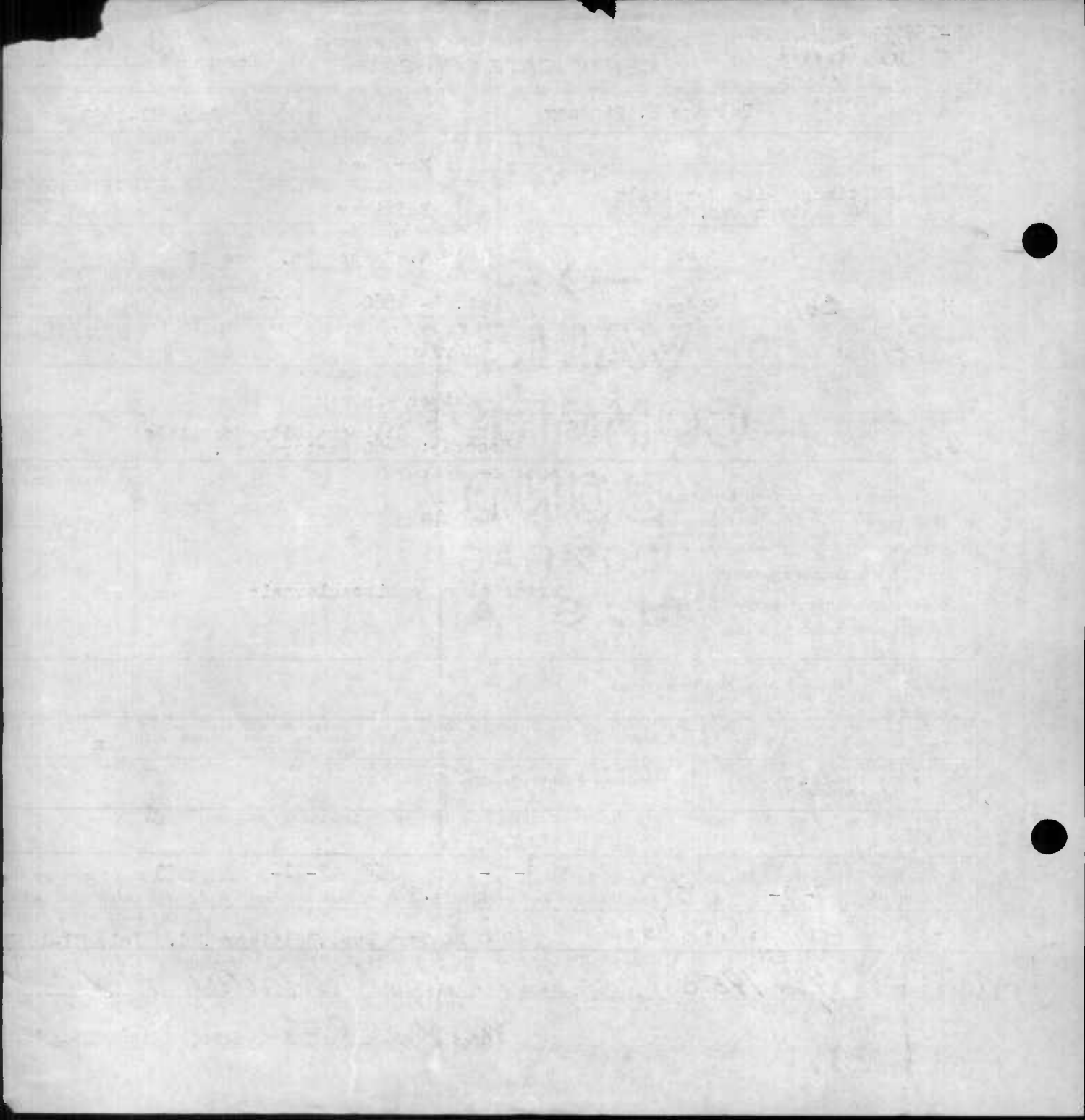
|  |                               |   |   |
|--|-------------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/21/1953</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Arbutus Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR                           |                               | 25. FUNERAL DIRECTOR<br><b>Mrs. Katis R. Williams</b>         | ADDRESS<br><b>322 N. Schrock St.</b>                                |

26. DATE RECEIVED BY LOCAL REGISTRAR  
**July 23 1953**

7-208A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6702  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Eattie M. Langley*2. DATE  
OF  
DEATH*July 22, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 11-04*

D. STREET ADDRESS (If rural, give location)

*216 W. Biddle St.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*Colored*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*8-14-15*9. AGE (In years  
last birthday)*37*10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18.

*600.0*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*uremia*

DUE TO

*14 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

*chronic pyelonephritis*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-17*, 1953, to *7-22*, 1953, that I last saw the  
deceased alive on *7-22*, 1953, and that death occurred at *8:15* p. m., from the causes and on the date stated above.

23A. SIGNATURE

*W. E. Keaton Jr.*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*7-23-53*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

*7/25/53 Flona Shouthbury*

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Huntington Williams, MD 985 Hull**JUL 23 1953**6703*

DEPARTMENT OF HEALTH  
STATE OF NEW YORK  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1. Name of deceased: *John J. Smith*

2. Date of death: *Jan 15 1912*

3. Place of death: *Home*

4. Cause of death: *Heart Disease*

5. Age: *45*

6. Sex: *Male*

7. Race: *White*

8. Religion: *Catholic*

9. Occupation: *Teacher*

10. Marital status: *Married*

11. Name of spouse: *John J. Smith*

12. Name of informant: *John J. Smith*

13. Address of informant: *123 Main St. Albany, N. Y.*

14. Signature of informant: *John J. Smith*

15. Date of registration: *Jan 15 1912*

16. Registrar's signature: *John J. Smith*

17. Registrar's name: *John J. Smith*

18. Registrar's address: *123 Main St. Albany, N. Y.*

19. Registrar's telephone: *1234*

20. Registrar's office: *Albany, N. Y.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-500  
53 6703

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6703  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clara E. Moon

2. DATE  
OF  
DEATH

July 22, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

8-03

D. STREET ADDRESS (If rural, give location)

1229 N. Ellwood Avenue

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1229 N. Ellwood Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 23, 1880

9. AGE (in years last birthday)

72

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Queen Anne's County, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Samuel J. Baxter

14. MOTHER'S MAIDEN NAME

Annie Collier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

C. Vennetta Baker, 1229 N. Ellwood Avenue

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ARTERIOSCLEROTIC HEART DISEASE

24 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

ARTERIOSCLEROSIS, GENERALIZED

10 yrs.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 1948, to 7/22/53, 19, that I last saw the deceased alive on 7/21/53, 19, and that death occurred at 1:15 m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin B. Moses, M.D.

23B. ADDRESS

448 N. Luzerne Ave.

23C. DATE SIGNED

7/22/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

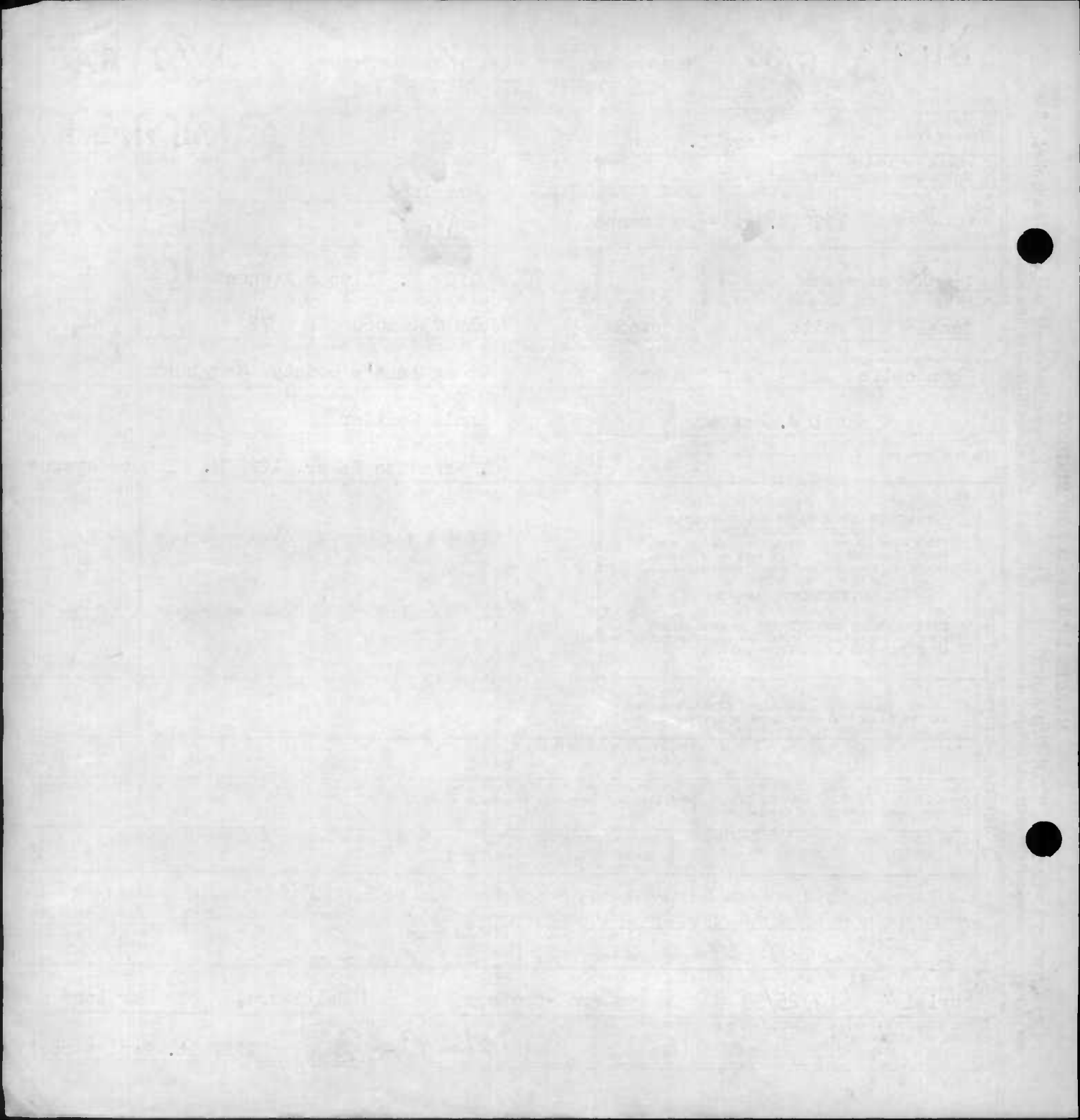
Wm. Cook, Inc.,

1217 St. Paul Street

JUL 23 1953

VS 150

MARGIN RESERVED FOR BINDING



S-532  
53 6704BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6704  
Registered No.

BIRTH NO.

|   |                               |   |  |  |   |
|---|-------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Edwin S. Sands,</i>   |                               |   | 2. DATE OF DEATH <i>July 23, 1953</i>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                               |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Maryland,</i> B. COUNTY <i>Baltimore,</i> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <i>Church &amp; Home Hospital</i>   |                               |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore, 27-10</i>  |  |   |
| Length of stay in Baltimore <i>25</i> → Yrs. Mos. Days  |                               |   | D. STREET ADDRESS (If rural, give location)<br><i>5302 St. George Avenue</i>   |  |   |
| 5. SEX<br><i>M.</i>   | 6. COLOR OR RACE<br><i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>M.</i>  | 8. DATE OF BIRTH<br><i>Nov. 2, 1963</i>  | 9. AGE (In years last birthday)<br><i>89</i>                             | 10. Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Office - B. &amp; O. R.R.</i>   |                               |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>retired</i>  |  |   |
| 11. FATHER'S NAME<br><i>Sands, William</i>  |                               |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                               |   | 16. SOCIAL SECURITY NO.<br><i>705 09 3976</i>  |  |   |
| 17. INFORMANT<br><i>Mrs. Middleton</i>  |                               |   | ADDRESS<br><i>5302 St. George Ave</i>  |  |   |
| 18. <i>584X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>uremia</i><br>DUE TO <i>old age &amp; post op course</i><br>ANTECEDENT CAUSES<br><i>jaundice</i><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Bile stones</i><br>(C) <i>Senility</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><i>48 hrs.</i><br><i>long time duration</i> |                               |   |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>None</i>  |                               |   |  |  |   |
| 19A. DATE OF OPERATION<br><i>7. 21. 53</i>  |                               |   | 19B. MAJOR FINDINGS OF OPERATION<br><i>Biliary stones</i>  |  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |   |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <i>7. 9. 1953</i> to <i>7. 23. 1953</i> that I last saw the deceased alive on <i>7. 23. 1953</i> and that death occurred at <i>15</i> m., from the causes and on the date stated above.  |                               |   |  |  |   |
| 23A. SIGNATURE<br><i>J. Nouri,</i>  |                               |   | 23B. ADDRESS<br><i>Church Home &amp; Hosp.</i>   |  | 23C. DATE SIGNED<br><i>7. 23. 53</i>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                               | 24B. DATE<br><i>7/23/53</i>   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mr. Morial Cemetery</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>Philadelphia, Penna</i> |
| DATE RECEIVED BY LOCAL REGISTRAR  |                               | REGISTRAR'S SIGNATURE<br><i>Wm. D. ...</i>  |  | 25. FUNERAL DIRECTOR<br><i>Wm. Cook, Inc.</i>                            |   |
|   |                               |   |  | ADDRESS<br><i>1217 St. Paul St</i>                                       |   |

MEDICAL CERTIFICATION

correct age is important. Physicians: please write the causes of death clearly and legibly.

239, 65, 140

44

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6705  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES W. OWENS

2. DATE  
OF DEATH July 22, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Maryland B. COUNTY before admission)B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

D. STREET ADDRESS (If rural, give location)

512 W. Mulberry St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

July 14, 1916

9. AGE (In years  
last birthday)

37

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Keeper of Apartment Houses

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Buffalo, New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James A. Owens

14. MOTHER'S MAIDEN NAME

Gertrude Bensch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gertrude Salz, 512 W. Mulberry Street

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Recent coronary occlusion, left coronary  
artery  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
July 23, 195324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore County, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

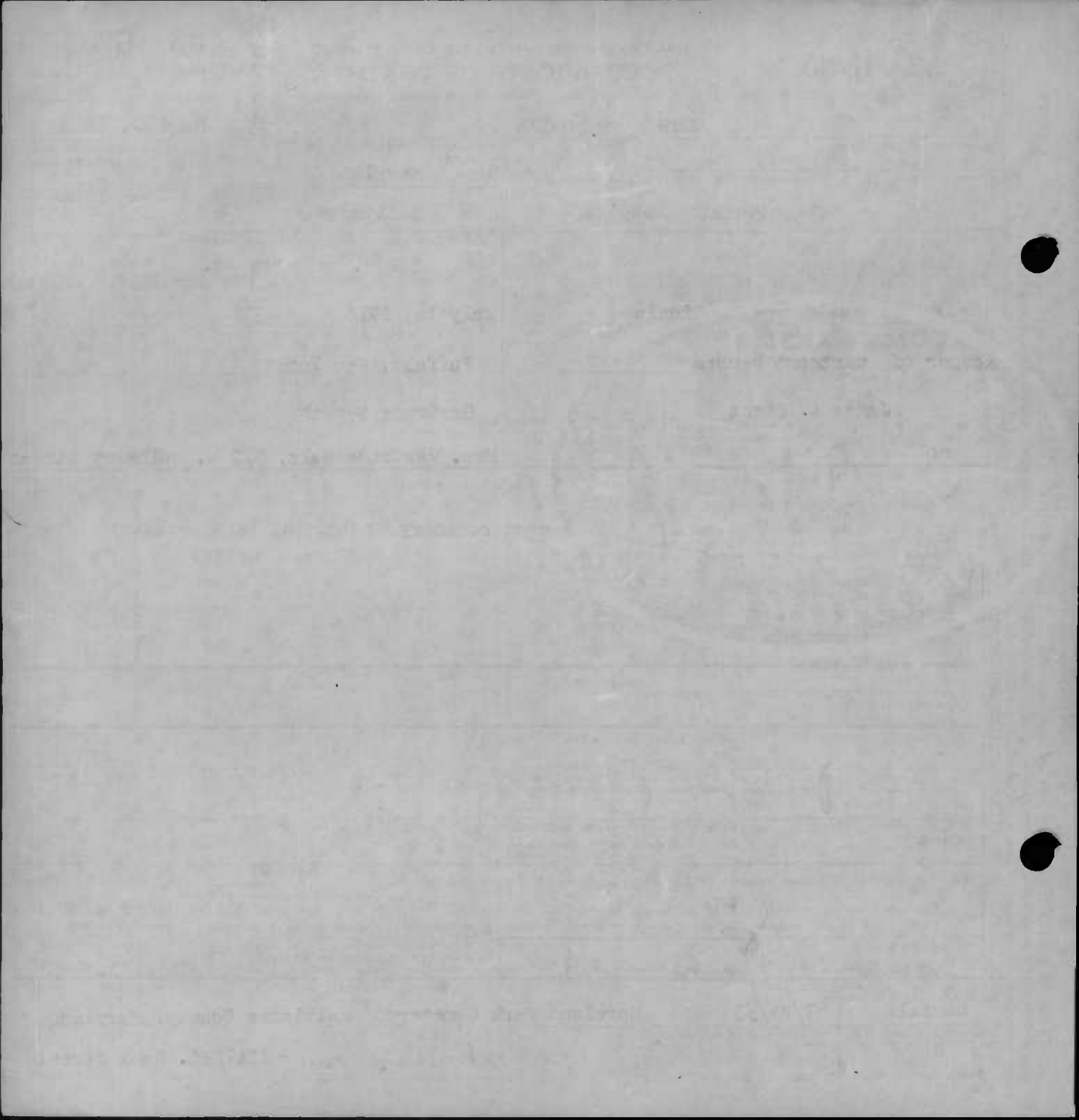
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc., 1217 St. Paul Street





0-231

53 5706

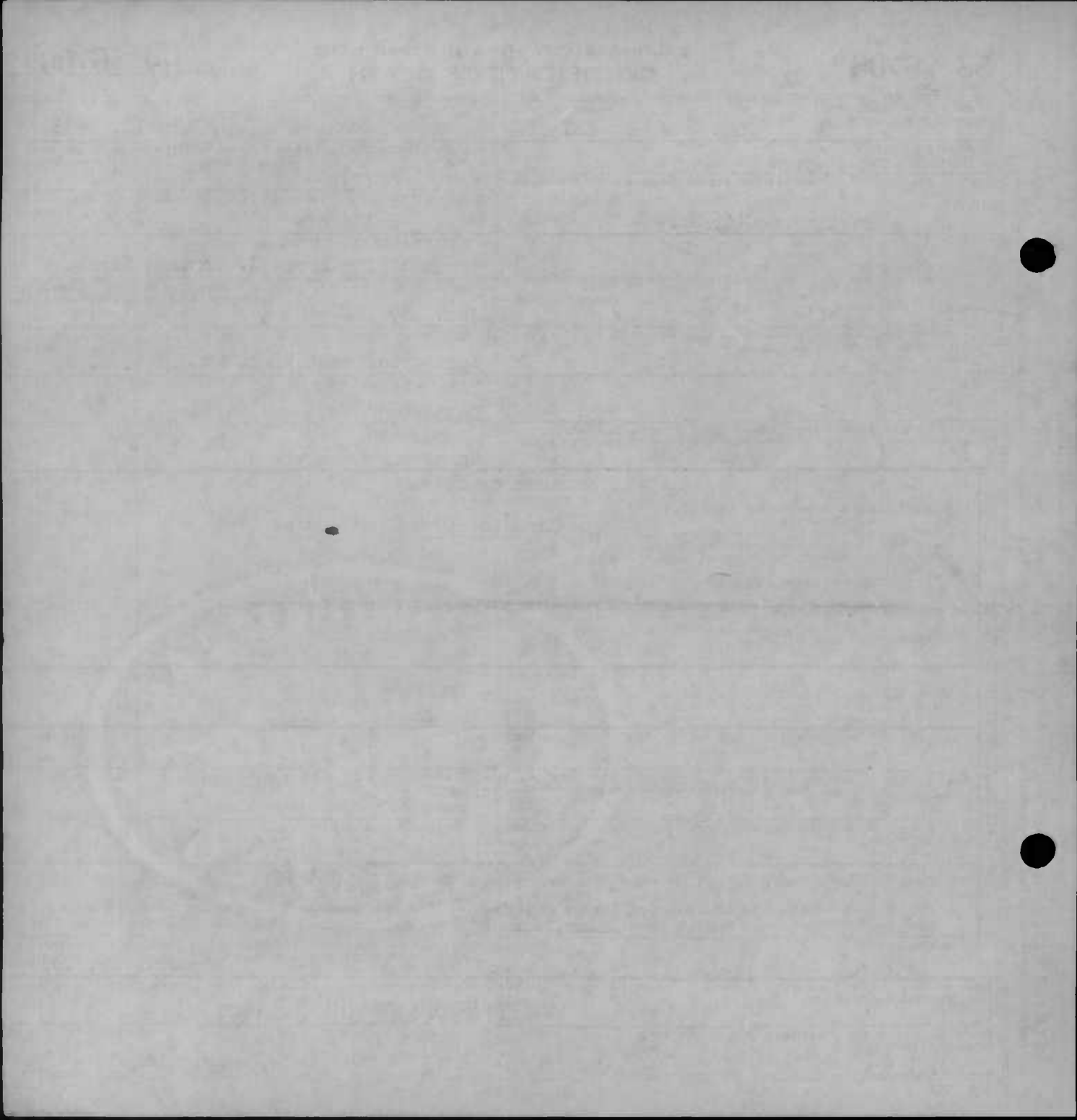
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6706

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN OSTAFIN</b>   |                                  |   | 2. DATE OF DEATH <b>July 10, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Morgue</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 0000</b>                          |  |  |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>Found: 100 block S. Kresson Street</b>                                       |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><b>Jan. 18, 1920</b>   | 9. AGE (In years last birthday)<br><b>33</b> | If Under 1 Year<br>Months: _____ Days: _____<br>If Under 24 Hours<br>Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N</b>              |                                  | 10B. KIND OF BUSINESS OR INDUSTRY               | 11. BIRTHPLACE (State or foreign country)<br><b>Springtown, West Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |
| 13. FATHER'S NAME<br><b>N</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>W</b> |                                  | 16. SOCIAL SECURITY NO.                         | 17. INFORMANT ADDRESS<br><b>Unknown</b>  |  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>322.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic alcoholism - probable</b><br>(A) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>(B) DUE TO   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) DUE TO   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph A. Jackson, M.D.</b>   |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 22, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>UNIVERSITY MEDICAL SCHOOL JUL 22 1953</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 23 1953</b>   |  | REGISTRAR'S SIGNATURE<br><b>H. J. Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Washington Williams, M.D.</b>                              |  |



|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 2-460<br>53 6707  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | X 53 6707<br>Registered No. _____   |  |
| 1. NAME OF DECEASED<br>(Last, first, middle, or Print)  |  | MARTHA AUGUSTA LILLER  |  | 2. DATE OF DEATH<br>July 23, 1953   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE<br>West Virginia   |  | B. COUNTY   |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>607 Reservoir Street   |  | C. CITY OR TOWN<br>Kaiser  |  | D. STREET ADDRESS (If rural, give location)<br>572 S. Water Street                                    |  |
| 6. LENGTH OF STAY IN BALTIMORE<br>Three weeks   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>divorced  |  | 8. DATE OF BIRTH<br>Jan. 31, 1893   |  |
| 9. SEX<br>F   |  | 10. COLOR OR RACE<br>W   |  | 11. AGE (In years last birthday)<br>60  |  |
| 12. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br>Housework  |  | 13. KIND OF BUSINESS OR INDUSTRY<br>at home  |  | 14. BIRTHPLACE (State or foreign country)<br>West Virginia  |  |
| 15. FATHER'S NAME<br>Jacob Green  |  | 16. SOCIAL SECURITY NO.  |  | 17. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>no  |  | 19. 17. INFORMANT<br>2332 Anoka Ave<br>Mrs. Samuel Wolfe   |  | 20. ADDRESS   |  |
| 21. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>156.2<br>(A) Respiratory failure<br>DUE TO<br>ANTECEDENT CAUSES<br>(B) Generalized Carcinomatosis<br>DUE TO<br>(C) Cause or source unknown<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | 22. INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 23. DATE OF OPERATION<br>Punch Biopsy Liver   |  | 24. MAJOR FINDINGS OF OPERATION<br>Revealed Carcinoma source unknown   |  | 25. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>21a. TIME (Month) (Day) (Year) (Hour) OF DEATH  |  | 27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21c. HOW DID INJURY OCCUR? |  |
| 29. I hereby certify that I attended the deceased from July 23, 1953, to July 25, 1953, that I last saw the deceased alive on July 21, 1953, and that death occurred at _____ m., from the causes and on the date stated above.   |  | 30. SIGNATURE<br>C. H. Homan   |  | 31. ADDRESS<br>2356 Euter Place   |  |
| 32. DATE<br>7/26/53   |  | 33. NAME OF CEMETERY OR CREMATORY<br>Warrenton Cem.  |  | 34. LOCATION (City, town, or county) (State)<br>Warrenton, Va.  |  |
| 35. RECEIVED BY<br>23 1953  |  | 36. REGISTRAR'S SIGNATURE<br>23 1953   |  | 37. FUNERAL DIRECTOR<br>HENRY SANDER & SONS, INC.<br>BALTO., 13, MD.                                  |  |
| VS 150  |  | George Sander  |  |   |  |

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H. 635  
53 6708

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6708  
Registered No.

|   |                       |   |                                    |
|---|-----------------------|---|------------------------------------|
| 1. NAME OF DECEASED<br>(Last, first, middle name or Print)  |                       | 2. DATE OF DEATH  |                                    |
| LOUISE HARTMEYER  |                       | July 21, 1953   |                                    |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland  |                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                                    |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>1731 E. Pratt Street   |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 2-02                          |                                    |
| 6. Length of stay in Baltimore Life   |                       | D. STREET ADDRESS (If rural, give location)<br>1731 E. Pratt Street   |                                    |
| 7. SEX<br>F   | 8. COLOR OR RACE<br>W | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow  | 10. DATE OF BIRTH<br>July 12, 1876 |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br>Housework  |                       | 12. AGE (In years last birthday)<br>77  |                                    |
| 13. FATHER'S NAME<br>John H. Buenger  |                       | 14. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes, give war or dates of service)<br>no   |                       | 16. CITIZEN OF WHAT COUNTRY?<br>USA   |                                    |
| 17. SOCIAL SECURITY NO.<br>none   |                       | 18. MOTHER'S MAIDEN NAME<br>Christina Schauman  |                                    |
| 19. INFORMANT<br>Mr. Herbert Hartmeyer  |                       | 20. 1731 E. Pratt Street  |                                    |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>CORONARY THROMBOSIS<br>DUE TO<br>CROON'S HEART DISEASE<br>& ARTERIO-SCLEROSIS<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>6 mos.<br>? |                       |   |                                    |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                       |   |                                    |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                       |   |                                    |
| 21. DATE OF OPERATION   |                       | 22. MAJOR FINDINGS OF OPERATION   |                                    |
| 23. DATE OF OPERATION   |                       | 24. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                    |
| 25. TIME (Month) (Day) (Year) (Hour)<br>OCCURRENCE OF INJURY  |                       | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                 |                                    |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                       | 28. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                                    |
| 29. INJURY OCCURRED   |                       | 30. HOW DID INJURY OCCUR?   |                                    |
| 31. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                       |   |                                    |
| 32. I hereby certify that I attended the deceased from July 1, 1953, to July 21, 1953, that I last saw the deceased alive on July 21, 1953, and that death occurred at 6:30 p.m., from the causes and on the date stated above.   |                       |   |                                    |
| 33. SIGNATURE<br>George Sander  |                       | 34. ADDRESS<br>2003 E. Pratt St.  |                                    |
| 35. DATE SIGNED<br>7/22/53  |                       | 36. DATE SIGNED   |                                    |
| 37. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                       | 38. DATE<br>7/24/53   |                                    |
| 39. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery   |                       | 40. LOCATION (City, town, or county)<br>Baltimore, Md.  |                                    |
| 41. DATE RECEIVED BY LOCAL REGISTRAR  |                       | 42. REGISTRAR'S SIGNATURE   |                                    |
| 43. FUNERAL DIRECTOR<br>HENRY SANDER & SONS, INC.   |                       | 44. ADDRESS<br>BALTO., 13, MD.  |                                    |
| 45. SIGNATURE<br>George Sander  |                       |   |                                    |

\_\_\_\_\_



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6709**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**HARRY****SCHLOTTERBECK**2. DATE  
OF  
DEATH**July 22, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

**Maryland**

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION**Franklin Square Hospital**C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)**Baltimore****20-01**

D. STREET ADDRESS (If rural, give location)

**1902 W. Mulberry Street**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

**Feb 2, 1893**9. AGE (In years  
last birthday)**60**If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**Laborer**10B. KIND OF BUSINESS OR  
INDUSTRY**Single**

11. BIRTHPLACE (State or foreign country)

**Hagerstown Md**12. CITIZEN OF  
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

**William H. Schlotterbeck**

14. MOTHER'S MAIDEN NAME

**Gennie B. Kreisler**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**No****None**16. SOCIAL  
SECURITY NO.

17. INFORMANT

**Father - Schlotterbeck**

ADDRESS

18. **581.1**

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **Coronary artery disease**~~XXXX~~ **Pulmonary edema**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) **Fatty metamorphosis of the liver**~~XXXX~~ **Chronic alcoholism**

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: **natural causes** ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Joseph A. Jachims**

23B. CHIEF MEDICAL EXAMINER.....

M.D.

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

**July 23, 1953**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

**7/23/53**

24C. NAME OF CEMETERY OR CREMATORY

**Rose Hill**

24D. LOCATION (City, town, or county)

**Hagerstown Md**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**1715 Boffman****Hagerstown Md**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-200

BALTIMORE CITY HEALTH DEPARTMENT

53 6710 53-16336

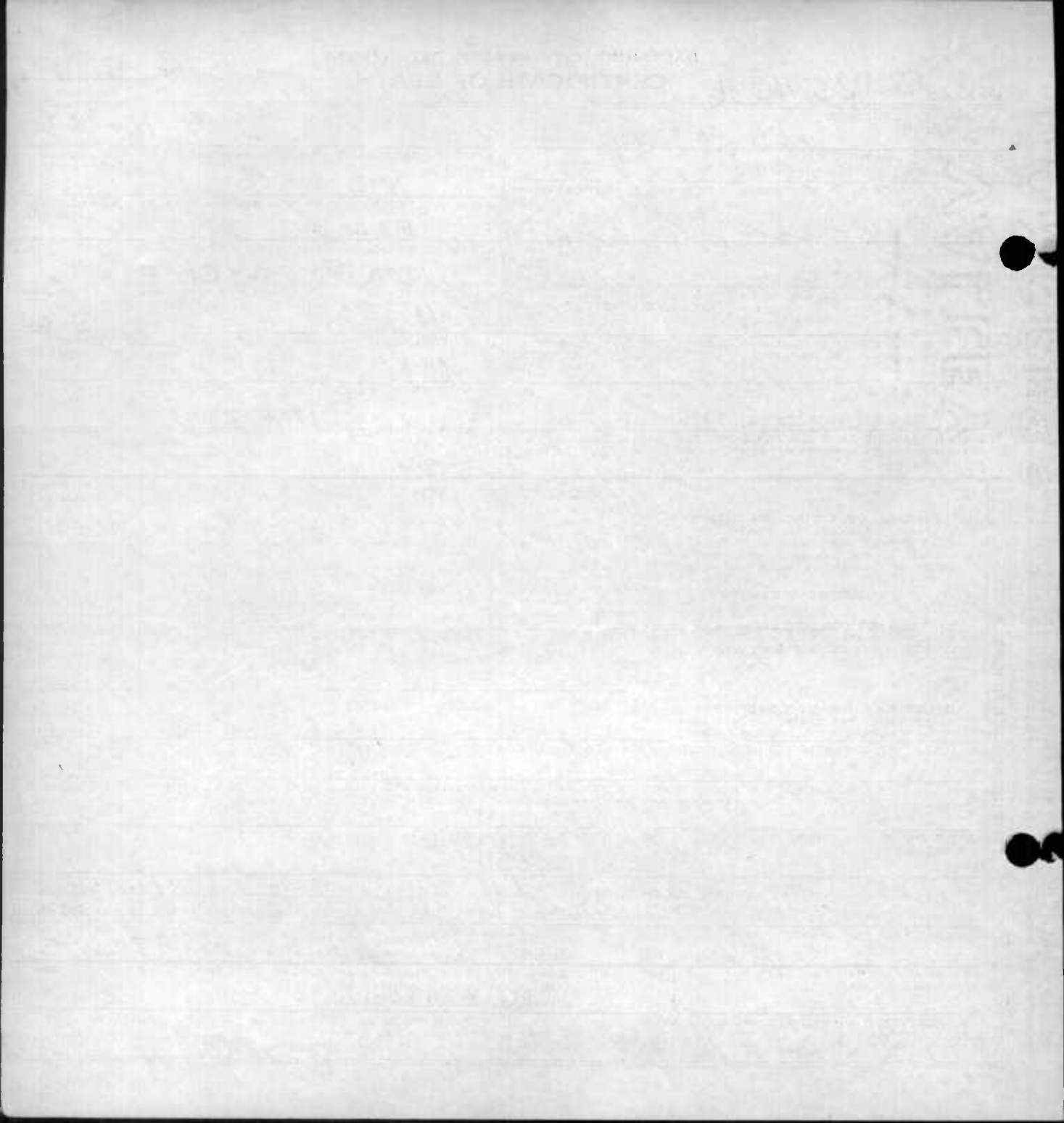
CERTIFICATE OF DEATH

Registered No. 53 6710

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Baby Boy Keys</u>                                 |                                 | 2. DATE OF DEATH <u>7-16-53</u>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>                          |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTO.</u> <u>19-02</u>               |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                 | D. STREET ADDRESS (If rural, give location) <u>1502 W. FAYETTE ST.</u>  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH <u>7-16-53</u>                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                                 | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <u>1</u> <u>00</u> <u>00</u> |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <u>George Hays Mc Kintey</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>Brown, INEZ</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                           |                                 | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT   |                                 | ADDRESS   |  |

|  |  |   |
|--|--|---|
| 18. <u>776 x I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) <u>prematurity</u><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1:30 min</u> |
| ANTECEDENT CAUSES<br>(B) <u>499 g. 15 1/2 yrs.</u><br>DUE TO   |  |   |
| (C)  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>7-16-53</u> , 19 <u>53</u> , to <u>7-16</u> , 19 <u>53</u> that I last saw the deceased alive on <u>7-16</u> , 19 <u>53</u> , and that death occurred at <u>2:20 P.m.</u> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE <u>W L Hennen</u>  |  | 23B. ADDRESS <u>University Hospital</u>   |  | 23C. DATE SIGNED <u>7-16-53</u>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>                 |  |
| DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 23 1953</u>   |  | REGISTRAR'S SIGNATURE <u>H.ington Williams, M.D.</u>  |  | 25. FUNERAL DIRECTOR <u>H.ington Williams, M.D.</u>                                 |  |
| VS 150  |  | ADDRESS   |  |   |  |



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| BALTIMORE CITY HEALTH DEPARTMENT  |                               |   |   | 53 6711   |   |
|---|-------------------------------|---|---|---|---|
| CERTIFICATE OF DEATH  |                               |   |   | Registered No.  |   |
| BIRTH No. 53 6711   |                               | 1. NAME OF DECEASED<br>(Type or Print) <i>Zachariah M. Harris</i>   |   | 2. DATE OF DEATH <i>July 23-1953</i>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Habsted 7</i>  |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>MD</i> |   | B. COUNTY <i>56-41</i>  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><i>33 JOHNS HOPKINS HOSPITAL</i>   |                               | C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township)<br><i>Westminster</i>         |   | D. STREET ADDRESS (If rural, give location)<br><i>Route 4</i>                       |   |
| c. Length of stay in Baltimore<br>Yrs. <i>3</i> Mos. <i>5</i> Days  |                               | 8. DATE OF BIRTH<br><i>6-7-79</i>   |   | 9. AGE (In years last birthday) <i>74</i>   |   |
| 5. SEX <i>male</i>  | 6. COLOR OR RACE <i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 11. BIRTHPLACE (State or foreign country)<br><i>Canoll co</i> |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Carpenter self employed</i>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 13. FATHER'S NAME<br><i>Am. M. Harris</i>   |   |
| 14. MOTHER'S MARDEN NAME<br><i>May Jane Blyzard</i>   |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)    |   | 16. SOCIAL SECURITY NO.<br><i>217-09-7829</i>                                       |   |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>  |                               | ADDRESS   |   |   |   |
| 18. <i>190x</i> CAUSE OF DEATH  |                               |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>5 years</i>                                  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>(A) malignant melanoma</i>  |                               |   |   |   |   |
| DUE TO  |                               |   |   |   |   |
| ANTECEDENT CAUSES   |                               |   |   |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                               |   |   |   |   |
| DUE TO  |                               |   |   |   |   |
| OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.  |                               |   |   |   |   |
| 19A. DATE OF OPERATION<br><i>May 9. 53</i>  |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Frontal Lobe injection</i>                           |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                   |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>4-30</i> , 19 <i>53</i> to <i>7-23</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7-23</i> , 19 <i>53</i> , and that death occurred at <i>7:10</i> p. m. from the causes and on the date stated above. |                               |   |   |   |   |
| 23A. SIGNATURE<br><i>H. Kuperman</i>  |                               | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |   | 23C. DATE SIGNED<br><i>7.23.53</i>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                               | 24B. DATE<br><i>July 25/53</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Kridus</i>                                 |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Canoll co.</i>  |                               | 25. FUNERAL DIRECTOR<br><i>H. B. Burkhard</i>   |   | ADDRESS<br><i>Saw Westminster Md.</i>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR  |                               | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>   |   |   |   |

JUL 23 1953  
VS 1503

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7. 1



-625

6712

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6712

TH NO.

NAME OF DECEASED  
(Last Name or Print)Augusta Mary Kirchner2. DATE  
OF  
DEATHJuly 22, 1953PLACE OF DEATH:  
Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MARYLAND

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 20-05443 S. BENTALOU St.

D. STREET ADDRESS (If rural, give location)

443 S. BENTALOU St.

Length of stay in Baltimore

65 yrs.Yrs.  
Mos.  
Days

SEX

Female white

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)widowed

8. DATE OF BIRTH

May 13, 18719. AGE (In years,  
last birthday)8210. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.1. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)Housewife10B. KIND OF BUSINESS OR  
INDUSTRYDomestic

11. BIRTHPLACE (State or foreign country)

MARYLAND12. CITIZEN OF  
WHAT COUNTRY?U.S.A

FATHER'S NAME

? LEAMANN

14. MOTHER'S MAIDEN NAME

? KETZERWAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)No NONE16. SOCIAL  
SECURITY NO.NONE

17. INFORMANT

ADDRESS

Miss Kirchner 443 S. Bentalou St.

18.

443X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic myocarditis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertension

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 21, 1953 to July 22, 1953 that I last saw the  
deceased alive on July 22, 1953 and that death occurred at 6 P. m. from the causes and on the date stated above.

23A. SIGNATURE

George E. Shannon

M. D.

23B. ADDRESS

20 Medical St. Bklyn

23C. DATE SIGNED

7/25/5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-25-53

24C. NAME OF CEMETERY OR CREMATORY

LORRAINE PARK

24D. LOCATION (City, town, or county)

BALTO. COUNTY

(State)

Md.25. FUNERAL RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

George L. Schwab 2101 Frederick Ave.

VS 150

100-100000

RECEIVED THE NEW YORK OFFICE  
FEBRUARY 10 1964

100-100000



-420

53 6713

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6713  
Registered No.NAME OF DECEASED  
(Last name or Print)

Louis Christopher Willhayeck

2. DATE  
OF  
DEATH

July 21, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

208 S. SMALLWOOD ST.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

70yrs.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.12. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)13. KIND OF BUSINESS OR  
INDUSTRY

14. BIRTHPLACE (State or foreign country)

15. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

16. MOTHER'S MAIDEN NAME

17. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)18. SOCIAL  
SECURITY NO.

19. INFORMANT

ADDRESS

1. 59yx

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1952 to July 21, 1953 that I last saw the  
deceased alive on July 20, 1953 and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1953

VS 150

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1910

1910

1910

|                  |  |                |  |                               |  |                   |  |                 |  |                 |  |                         |  |                        |  |
|------------------|--|----------------|--|-------------------------------|--|-------------------|--|-----------------|--|-----------------|--|-------------------------|--|------------------------|--|
| Name of Deceased |  | Sex            |  | Age                           |  | Date of Death     |  | Place of Death  |  | Cause of Death  |  | Signature of Physician  |  | Signature of Registrar |  |
| John Doe         |  | Male           |  | 45                            |  | Jan 15, 1910      |  | Boston, Mass.   |  | Heart Disease   |  | J. A. Smith             |  | W. B. Jones            |  |
| Occupation       |  | Marital Status |  | Date of Birth                 |  | Time of Death     |  | Manner of Death |  | Place of Burial |  | Signature of Undertaker |  | Signature of Minister  |  |
| Teacher          |  | Married        |  | Jan 1, 1865                   |  | 10:30 AM          |  | Natural         |  | Cemetery        |  | C. D. Green             |  | R. E. White            |  |
| Usual Residence  |  | Place of Birth |  | Date of Admission to Hospital |  | Date of Discharge |  | Date of Death   |  | Date of Burial  |  | Date of Interment       |  | Date of Cremation      |  |
| 123 Main St.     |  | New York       |  | Jan 10, 1910                  |  | Jan 12, 1910      |  | Jan 15, 1910    |  | Jan 16, 1910    |  | Jan 17, 1910            |  | Jan 18, 1910           |  |
| Usual Residence  |  | Place of Birth |  | Date of Admission to Hospital |  | Date of Discharge |  | Date of Death   |  | Date of Burial  |  | Date of Interment       |  | Date of Cremation      |  |
| 123 Main St.     |  | New York       |  | Jan 10, 1910                  |  | Jan 12, 1910      |  | Jan 15, 1910    |  | Jan 16, 1910    |  | Jan 17, 1910            |  | Jan 18, 1910           |  |

5-361  
3 6714

ANNA E. STRUBING  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6714  
Registered No.

TH NO.

|  |   |   |  |
|--|---|---|--|
| NAME OF DECEASED<br>(Last, first, middle, or Print) <i>Anna Elizabeth Strubing</i>   |   | 2. DATE OF DEATH<br><i>7-22 1953</i>  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland <i>700 Harbor Road</i>   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Anne Arundel</i> |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>Snyder Convalescent Home</i>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore Md 26-02</i>                                 |  |
| Length of stay in Baltimore <i>58 years</i>  |   | D. STREET ADDRESS (If rural, give location)<br><i>5108 Anthony Avenue</i>   |  |
| SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>Dec 3 1872-80</i>                                   |
| 9. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><i>Housewife</i>   |   | 10a. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><i>Germany</i>                |
| FATHER'S NAME<br><i>Heiserman, Jimmy</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>Yes</i>  |  |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Caroline Gerhardt</i>  |  |
| 15. SOCIAL SECURITY NO.  |   | 16. INFORMANT<br><i>John Strubing</i>   |  |
| 18. <i>E903.0 1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Hypostatic Pneumonia</i> |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1953</i>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Fracture of Right Femur</i>   |   | CERTIFICATION APPROVED BY<br><i>John Strubing</i><br>M. D.  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   | CHIEF OR ASST. MEDICAL EXAMINER.<br><i>Chr. Myrland</i>   |  |
| 19a. DATE OF OPERATION<br><i>June 24-1953</i>  |   | 19b. MAJOR FINDINGS OF OPERATION<br><i>Fracture of Right Femur</i>  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input checked="" type="checkbox"/>   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><i>5108 ANTHONY AVE</i> | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><i>Baeture 26/2</i>   |  |
| 21d. TIME (Month) (Day) (Year) OF INJURY<br><i>June 29 1953</i>  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   | 21f. HOW DID INJURY OCCUR?<br><i>slipped and fell off at stairs to floor</i>  |  |
| 22. I hereby certify that I attended the deceased from <i>D.O.F.</i> , 19__, to <i>JULY 22, 1953</i> , that I last saw the deceased alive on __, 19__, and that death occurred at <i>617</i> m., from the causes and on the date stated above.       |   |   |  |
| 23a. SIGNATURE<br><i>Chris P. Clauser</i>  |   | 23b. ADDRESS<br><i>3003 St Paul St</i>  |  |
| 23c. DATE SIGNED<br><i>July 27</i>   |   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Buried</i>   | 24b. DATE<br><i>July 25, 1953</i>   | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cemetery</i>   | 24d. LOCATION (City, town, or county) (State)<br><i>Baltimore Maryland</i> |
| 25. RECEIVED BY<br>CAL REGISTRAR<br><i>Huntington Williams</i>   | 26. REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   | 27. FUNERAL DIRECTOR<br><i>Albert P. Welf</i>   | 28. ADDRESS<br><i>4642 Belair Road</i>                                     |
| VS 150<br><i>to be at Dr. Vester</i>   |   |   |  |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**D-450**  
**53 6715**

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **53 6715**

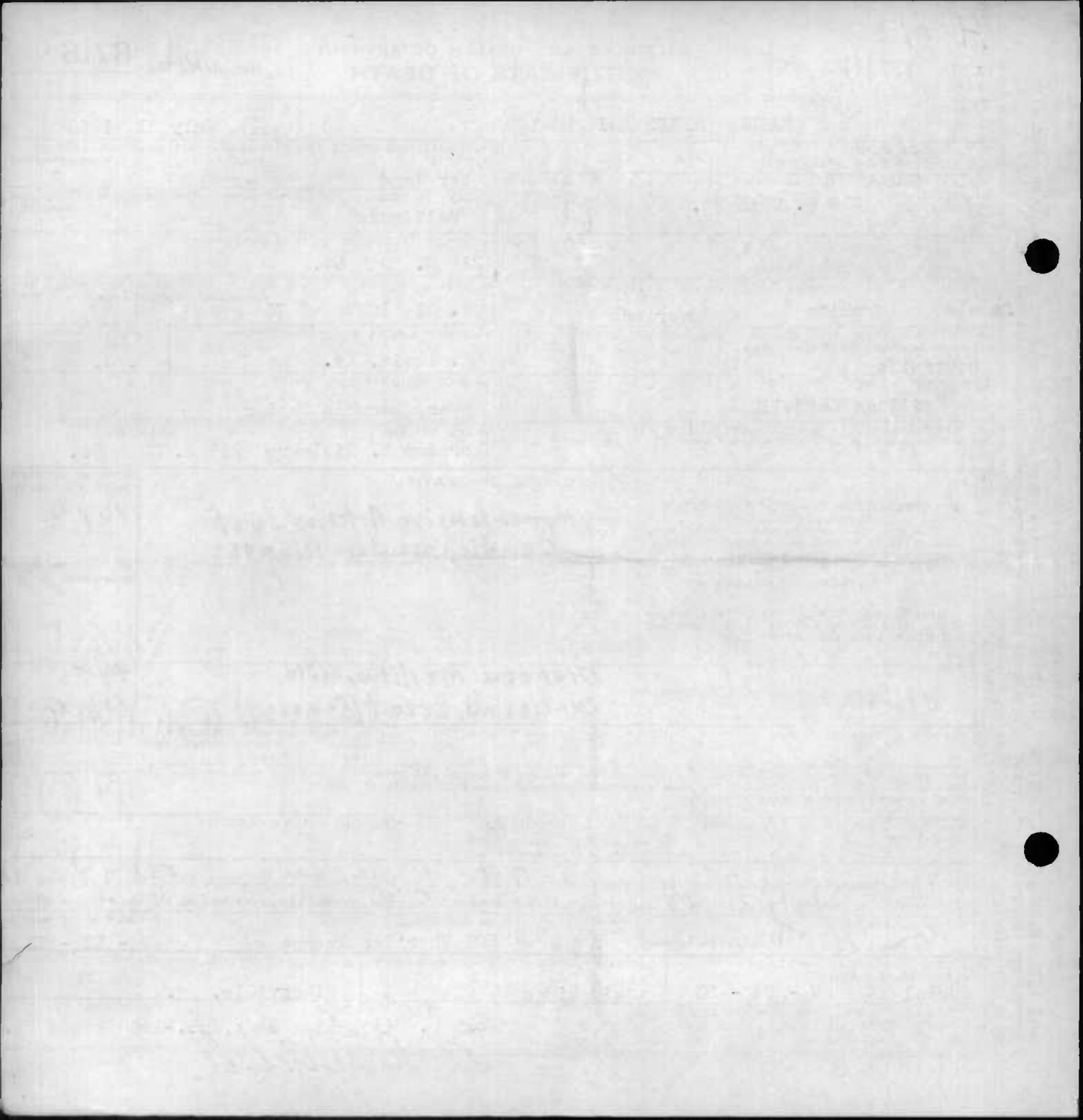
|  |                               |   |                                       |  |  |
|--|-------------------------------|---|---------------------------------------|--|--|
| BIRTH NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA DORA DULIN</b>   |                                       | 2. DATE OF DEATH <b>July 22, 1953</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>none</b> |                                       |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2409 Edmondson Ave.</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-02</b>                              |                                       |  |  |
| c. Length of stay in Baltimore <b>31</b> Yrs. Mos. Days  |                               | D. STREET ADDRESS (If rural, give location) <b>2409 Edmondson Ave.</b>  |                                       |  |  |
| 5. SEX <b>female</b>   | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>  | 8. DATE OF BIRTH <b>8 - 26 - 1881</b> | 9. AGE (In years last birthday) <b>71</b>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY   |                                       | 11. BIRTHPLACE (State or foreign country) <b>Easton, Maryland</b>                        |  |
| 13. FATHER'S NAME <b>Charles Wesley</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Isabelle</b>  |                                       | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.   |                                       | 17. INFORMANT <b>Catonsville, Md. Mrs. Viola Rice 415 Stratford Road.</b>                |  |
| 18. <b>420.1 and 170X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Coronary Artery Disease</b><br>DUE TO<br>(B) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>years</b> |                               | CERTIFICATION APPROVED BY<br><b>Joseph H. Jarkins, M.D.</b><br>CHIEF DR. ASST. MEDICAL EXAMINER   |                                       |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Carcinoma of Breast</b>   |                               |   |                                       |  |  |
| 19A. DATE OF OPERATION <b>7 - 25 - 53</b>  |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                       | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                 |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |                                       | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>never</b> , 19__, to __, 19__, that I last saw the deceased alive on <b>never</b> , 19__, and that death occurred at __ m., from the causes and on the date stated above.  |                               |   |                                       |  |  |
| 23A. SIGNATURE <b>James Moran</b>  |                               | 23B. ADDRESS <b>6014 Edmondson Ave.</b>   |                                       | 23C. DATE SIGNED <b>7-22-53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 24B. DATE <b>7 - 25 - 53</b>  |                                       | 24C. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>                                    |  |
| 24D. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>   |                               | 25. FUNERAL DIRECTOR ADDRESS <b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place</b>  |                                       |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1953</b>  |                               | REGISTRAR'S SIGNATURE <b>Huntington Williams</b>  |                                       | 25. FUNERAL DIRECTOR ADDRESS <b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place</b> |  |

WILLIAM

CLARK

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6716

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MABEL HEPLER HILLEARY</b>   |                                  |  | 2. DATE OF DEATH <b>July 21, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>219 W. 29th St.</b>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |   |
| c. Length of stay in Baltimore <b>60</b> Yrs. Mos. Days   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>219 W. 29th St.</b>  |  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>  | 8. DATE OF BIRTH<br><b>Nov. 22, 1877</b>   | 9. AGE (In years last birthday)<br><b>75</b>                             | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>St. Louis, Mo.</b>   |  |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |   |
| 13. FATHER'S NAME<br><b>William Saffell</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Snowden Hepler</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  |  | 16. SOCIAL SECURITY NO.  |  |   |
| 17. INFORMANT<br><b>Thornton E. Hilleary</b>  |                                  |  | ADDRESS<br><b>219 W. 29th St.</b>  |  |   |
| 18. <b>443 X and 260 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>(B) _____<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b> |                                  |  |  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>(C) _____  |                                  |  |  |  |   |
| 11<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Diabetes Mellitus, Mild</b><br><b>Carcinoma, Breast (Removed)</b>  |                                  |  | <b>4 yrs.</b><br><b>15 yrs.</b>  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>Oct. 1952</b> , to <b>July 1953</b> , that I last saw the deceased alive on <b>July 21, 1953</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.  |                                  |  |  |  |   |
| 23A. SIGNATURE<br><b>Wm. H. Kammer, Jr.</b>   |                                  | M. D.  |  | 23B. ADDRESS<br><b>501 Sheridan Avenue</b>                               |   |
| 23C. DATE SIGNED<br><b>7-22-53</b>  |                                  |  |  |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7-24-53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                 |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b>   |                                  |  |  |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 24 1953</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |  | 25. FUNERAL DIRECTOR<br><b>John O. Mitchell &amp; Sons, Inc.</b>         |   |
|   |                                  |  |  | ADDRESS<br><b>-1900 Eutaw Pl.</b>  |   |



5-534  
53 6717BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH83 6717  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SADIE SINDLER (GILDEN)

2. DATE  
OF  
DEATH

7-22-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4613 Park Hgts

4. USUAL RESIDENCE (Where deceased lived, If institution; residence

A. STATE

B. COUNTY

(before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Mt Sinai Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3810 Fanner Road

C. Length of stay in Baltimore

49

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

Female

white

widow

60

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Housewife

Poland

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Abraham Jontiff

Sora

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

(If yes, give war or dates of service)

Edna Jontiff - Same

18.

170X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) General Carcinomatosis  
flow ca. of breast

1949

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Arterioscl. Heart Dis + Cardiac  
Necrosis

1950

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from Oct 2 1950 to July 22, 1953, that I last saw the  
deceased alive on July 7, 1953, and that death occurred at 11:27 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Edna Jontiff

M. D. 6707 Park Heights AVE

July 23, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-24-53

Beth Tfelok

Balto Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1953

Huntington

Jack Newell 2100 Butler Pl

James Cohen  
6702 Park Hgts  
Ro 4-1441

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WASHINGTON AND HEAVEN DISTRICT  
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

SIGNATURE OF MINISTER

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF DISTRICT ATTORNEY

SIGNATURE OF COUNTY CLERK

SIGNATURE OF STATE CLERK

SIGNATURE OF SECRETARY OF STATE

SIGNATURE OF GOVERNOR

SIGNATURE OF VICE GOVERNOR

SIGNATURE OF COMMISSIONER OF HEALTH

SIGNATURE OF COMMISSIONER OF LABOR

SIGNATURE OF COMMISSIONER OF EDUCATION

SIGNATURE OF COMMISSIONER OF AGRICULTURE

SIGNATURE OF COMMISSIONER OF MINES



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6718**

**BIRTH NO.** **53 6718**

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Alice Larmia Gaver</i>   |                                  | 2. DATE OF DEATH<br><i>July 23/1953</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>6000 Bellona Ave</i>                                      |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>W</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Edgewood Nursing Home</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Washington DC</i>                           |  |
| c. Length of stay in Baltimore<br><i>8 mos</i>   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>1514 17th St. N.W. V. 48</i>   |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><i>Single</i>  | 8. DATE OF BIRTH<br><i>Nov 17/1868</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Ed. Club</i> |                                  | 11. BIRTHPLACE (State or foreign country)<br><i>Middletown Md.</i>   |  |
| 13. FATHER'S NAME<br><i>William F. Gaver</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S. Government</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><i>Alma G. Biggs</i>  |                                  | ADDRESS<br><i>3801 Juniper Road</i>  |  |

|  |   |   |
|--|---|---|
| 18. <i>334X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <i>arteriosclerosis - generalized atherosclerosis</i><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____ | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs.</i> |
|--|---|---|

|   |  |   |
|---|--|---|
| 19A. DATE OF OPERATION<br><i>0</i>                    | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____      |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____  |

22. I hereby certify that I attended the deceased from *10/25/52*, 19\_\_, to *7/23/53*, 19\_\_, that I last saw the deceased alive on *7/22/53*, 19\_\_, and that death occurred at *9:45 P.m.*, from the causes and on the date stated above.

|   |  |  |
|---|--|--|
| 23A. SIGNATURE<br><i>Francis W. Gaver</i>                     | 23B. ADDRESS<br><i>100 W. Annapolis Pkwy</i> | 23C. DATE SIGNED<br><i>7/24/53</i>                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Crematory</i> | 24B. DATE<br><i>July 24/1953</i>             | 24C. NAME OF CEMETERY OR CREMATORY<br><i>London Park</i> |
| 24D. LOCATION (City, town, or county)<br><i>Balto Md.</i>     |  | 24E. FUNERAL DIRECTOR<br><i>William W. Gaver</i>         |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 24 1953</i>        |  | ADDRESS<br><i>4204 Edgewood Ave</i>                      |

correct age is especially important. Physicians: please write the cause of death.

MEDICAL CERTIFICATION



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-400

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

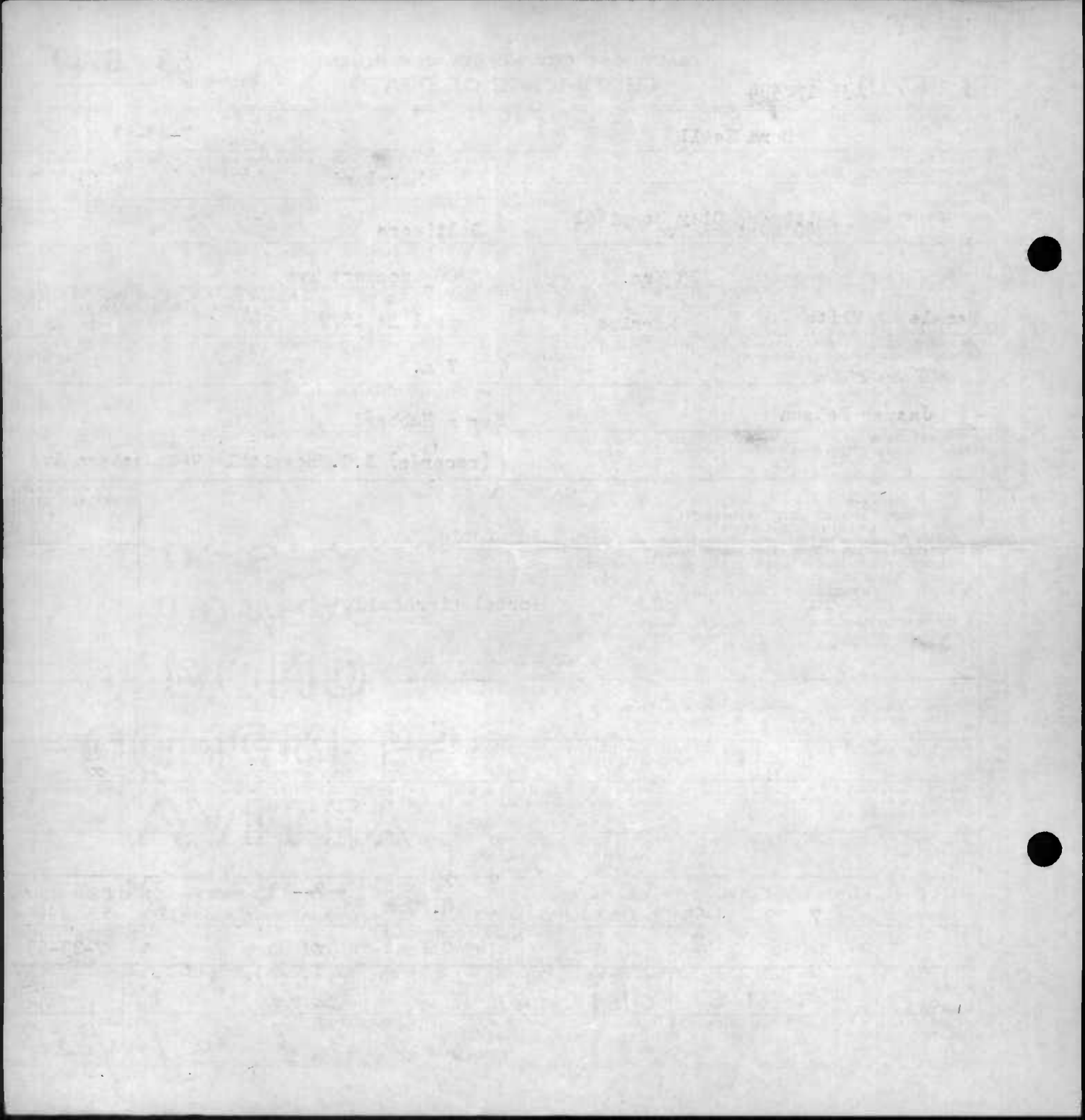
Registered No. 53 6719

53 6719 Jh 172584

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Belle Dora Beall</b>  |                                  | 2. DATE OF DEATH<br><b>7-23-53</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospital<br/>4940 Eastern Ave</b>                |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-03</b>                      |  |
| c. Length of stay in Baltimore <b>23 Yrs.</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>3208 Rueckert Ave</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>april 19, 1879</b>    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AT HOME</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (in years last birthday)<br><b>74</b> |
| 13. FATHER'S NAME<br><b>Jasper Nelson</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>V a.</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 16. SOCIAL SECURITY NO.   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Hubbard</b>  |  |
| 17. INFORMANT (records) <b>B.C. Hospital</b>  |                                  | ADDRESS<br><b>4940 Eastern Ave</b>  |  |

|   |                |                             |                                  |
|---|----------------|-----------------------------|----------------------------------|
| 18. <b>581.0</b>  | CAUSE OF DEATH |                             | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                | (A) <b>Pneumonia</b>        |                                  |
| ANTECEDENT CAUSES   |                | (B) <b>Portal Cirrhosis</b> |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                | (C)                         |                                  |

|  |   |  |   |
|--|---|--|---|
| II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |   |
| 19A. DATE OF OPERATION<br><b>7-22-53</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7-22-53</b> , to <b>7-23-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-23-53</b> , and that death occurred at <b>8.20am</b> m., from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><b>Hyphen Dec.</b>   | 23B. ADDRESS<br><b>4940 Eastern Ave</b>   | 23C. DATE SIGNED<br><b>7-23-53</b>                                       |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7-27-53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>glen Haven Park</b>             | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO Md</b>                    |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE   | 25. FUNERAL DIRECTOR<br><b>Leonard J. Ruck</b>                           | ADDRESS<br><b>5305 Sanford Rd</b>   |



M-460

53 6720

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6720  
Registered No.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY MILLER</b>  |   |   | 2. DATE OF DEATH<br><b>July 23, 1953</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   |   | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY                          |   |   |
| B. FULL NAME OF (not in hospital or institution, give street address or location)<br><b>Baltimore City Morgue</b>  |   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 2-03</b>   |   |   |
| c. Length of stay in Baltimore <b>73</b> Yrs. Mos. Days  |   |   | D. STREET ADDRESS (If rural, give location)<br><b>1715 Lancaster St.</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>                    | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>   | 8. DATE OF BIRTH<br><b>11-27-62</b>   | 9. AGE (In years last birthday)<br><b>90</b>  | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Ireland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                 |
| 13. FATHER'S NAME<br><b>?</b>  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>John Drane 1715 Lancaster St.</b>   |   |   |
| 18. <b>4221</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |   | INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| 19A. DATE OF OPERATION   |   | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that I took charge of the remains described above, held an <b>inspection &amp; inquiry</b> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .         |   |   |   |   |   |
| 23A. SIGNATURE<br><b>Joseph G. Jachimczyk</b> M.D.   |   |   | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... |   | 23C. DATE SIGNED<br><b>July 23, 1953</b>                      |
| 24A. BURIAL, CREMATION, REMOVAL Specify:<br><b>Burial</b>  | 24B. DATE<br><b>3-25-53</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |   |   |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Lilly &amp; Ziehl</b>  |   | ADDRESS<br><b>403 S. Noe St.</b>  |   |

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6721  
Registered No. \_\_\_\_\_

TH No. 6721

|  |  |  |   |
|--|--|--|---|
| NAME OF DECEASED<br>(Last, first, middle, or Print) <b>HARRISON RIDER</b>  |  | 2. DATE OF DEATH <b>7/22/53</b>  |   |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>TOWSON-4</b>  |   |
| Length of stay in Baltimore <b>LIFE</b>  |  | D. STREET ADDRESS (If rural, give location)<br><b>LOCH RAVEN + HILLEN ROAD</b>   |   |
| SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>   | 8. DATE OF BIRTH <b>2/15/1865</b>                                   |
| 9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>city commissioner</b>   |  | 10. KIND OF BUSINESS OR INDUSTRY <b>?</b>  |   |
| FATHER'S NAME <b>JOHN G. RIDER</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>UNKNOWN</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>US</b>   |   |
| 16. SOCIAL SECURITY NO. <b>217-14-3601</b>   |  | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANN HOOK</b>   |   |
| 17. INFORMANT <b>K. V. ROE</b>   |  | ADDRESS <b>ROXTON-4, MD.</b>   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Exact cause undetermined</b>         |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>possibly pulmonary edema</b>  |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>in circulatory shock</b>   |  |  |   |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>urinary retention - high fever - tachycardia</b>  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF DEATH   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7-18-1953</b> to <b>7-22-1953</b> that I last saw the deceased alive on <b>7-22-1953</b> and that death occurred at <b>7:28 p.m.</b> , from the causes and on the date stated above. |  |  |   |
| 23A. SIGNATURE<br><b>Marjorie H. Hendry</b>  |  | 23B. ADDRESS<br><b>Union Memorial Hosp.</b>  | 23C. DATE SIGNED<br><b>7-22-53</b>                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 24B. DATE <b>7-25-1953</b>   | 24C. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>  | 24D. LOCATION (City, town, or county) (State) <b>PIKESVILLE MD.</b> |
| 25. RECEIVED BY<br>LOCAL REGISTRAR <b>24 1953</b>  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  | 25. FUNERAL DIRECTOR<br><b>H. W. JENKINS &amp; SONS Co.</b>  | ADDRESS<br><b>4905 YORK RD.</b>                                     |

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
OFFICE: [illegible]

[Faint, illegible text and markings at the bottom of the page, possibly including a date stamp or additional administrative notes.]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6722

BIRTH NO. 53 6722

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>AUGUST A. MARK</b>  |                                  |   | 2. DATE OF DEATH <b>July 22, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>4315 Parkwood Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 26-02</b>                         |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>4315 Parkwood Avenue</b>   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | B. DATE OF BIRTH<br><b>July 16-1888 64</b>   |  | 9. AGE (in years last birthday)<br><b>64</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Electrician</b>                           |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>August Mark</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Not Known</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                     |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Margaret Mark 4315 Parkwood Ave.</b>   |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteriuscular</b><br>DUE TO<br><b>Heart Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>(C)   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that I took charge of the remains described above, held an _____ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |  |   |  |  |  |
| 23A. SIGNATURE<br><b>R. F. Fisher</b>  |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 22, 1953</b>                                 |  |

|  |                                |  |  |
|--|--------------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 25-53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>                 | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 24 1953</b>     |                                | 25. FUNERAL DIRECTOR ADDRESS<br><b>John R. Miller 1334 Jefferson St.</b> |  |

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6723

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><i>John H. Hein</i>  |                                  | 2. DATE OF DEATH<br><i>July 22-1953</i>   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>608 N. Montford Ave.</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto.</i>                             |  |
| 6. LENGTH OF stay in Baltimore<br>Yrs. <i>0</i><br>Mos. <i>0</i><br>Days <i>0</i>   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>608 N. Montford Ave.</i>  |  |
| 7. SEX<br><i>Male</i>   | 8. COLOR OR RACE<br><i>White</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>  | 10. DATE OF BIRTH<br><i>July 20-1885</i> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><i>Broom Maker</i>   |                                  | 12. AGE (In years last birthday)<br><i>68</i>   |  |
| 13. FATHER'S NAME<br><i>Casper Hein</i>   |                                  | 14. BIRTHPLACE (State or foreign country)<br><i>Balto., Md</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>  |                                  | 16. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  |
| 17. SOCIAL SECURITY NO.   |                                  | 18. MOTHER'S MAIDEN NAME<br><i>Annie Lutz</i>   |  |
| 19. INFORMANT<br><i>Madeline Benny</i>  |                                  | 20. ADDRESS<br><i>608 N. Montford Ave.</i>  |  |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral Thrombosis</i> |                                  | 22. INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i>   |  |
| 23. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Acute Cardiac Failure</i>  |                                  | 24. DUE TO<br><i>Generalized Arteriosclerosis</i>   |  |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  | 26. 5 yrs.  |  |
| 27. DATE OF OPERATION   |                                  | 28. MAJOR FINDINGS OF OPERATION   |  |
| 29. DATE OF OPERATION   |                                  | 30. MAJOR FINDINGS OF OPERATION   |  |
| 31. DATE OF OPERATION   |                                  | 32. MAJOR FINDINGS OF OPERATION   |  |
| 33. DATE OF OPERATION   |                                  | 34. MAJOR FINDINGS OF OPERATION   |  |
| 35. DATE OF OPERATION   |                                  | 36. MAJOR FINDINGS OF OPERATION   |  |
| 37. DATE OF OPERATION   |                                  | 38. MAJOR FINDINGS OF OPERATION   |  |
| 39. DATE OF OPERATION   |                                  | 40. MAJOR FINDINGS OF OPERATION   |  |
| 41. DATE OF OPERATION   |                                  | 42. MAJOR FINDINGS OF OPERATION   |  |
| 43. DATE OF OPERATION   |                                  | 44. MAJOR FINDINGS OF OPERATION   |  |
| 45. DATE OF OPERATION   |                                  | 46. MAJOR FINDINGS OF OPERATION   |  |
| 47. DATE OF OPERATION   |                                  | 48. MAJOR FINDINGS OF OPERATION   |  |
| 49. DATE OF OPERATION   |                                  | 50. MAJOR FINDINGS OF OPERATION   |  |
| 51. DATE OF OPERATION   |                                  | 52. MAJOR FINDINGS OF OPERATION   |  |
| 53. DATE OF OPERATION   |                                  | 54. MAJOR FINDINGS OF OPERATION   |  |
| 55. DATE OF OPERATION   |                                  | 56. MAJOR FINDINGS OF OPERATION   |  |
| 57. DATE OF OPERATION   |                                  | 58. MAJOR FINDINGS OF OPERATION   |  |
| 59. DATE OF OPERATION   |                                  | 60. MAJOR FINDINGS OF OPERATION   |  |
| 61. DATE OF OPERATION   |                                  | 62. MAJOR FINDINGS OF OPERATION   |  |
| 63. DATE OF OPERATION   |                                  | 64. MAJOR FINDINGS OF OPERATION   |  |
| 65. DATE OF OPERATION   |                                  | 66. MAJOR FINDINGS OF OPERATION   |  |
| 67. DATE OF OPERATION   |                                  | 68. MAJOR FINDINGS OF OPERATION   |  |
| 69. DATE OF OPERATION   |                                  | 70. MAJOR FINDINGS OF OPERATION   |  |
| 71. DATE OF OPERATION   |                                  | 72. MAJOR FINDINGS OF OPERATION   |  |
| 73. DATE OF OPERATION   |                                  | 74. MAJOR FINDINGS OF OPERATION   |  |
| 75. DATE OF OPERATION   |                                  | 76. MAJOR FINDINGS OF OPERATION   |  |
| 77. DATE OF OPERATION   |                                  | 78. MAJOR FINDINGS OF OPERATION   |  |
| 79. DATE OF OPERATION   |                                  | 80. MAJOR FINDINGS OF OPERATION   |  |
| 81. DATE OF OPERATION   |                                  | 82. MAJOR FINDINGS OF OPERATION   |  |
| 83. DATE OF OPERATION   |                                  | 84. MAJOR FINDINGS OF OPERATION   |  |
| 85. DATE OF OPERATION   |                                  | 86. MAJOR FINDINGS OF OPERATION   |  |
| 87. DATE OF OPERATION   |                                  | 88. MAJOR FINDINGS OF OPERATION   |  |
| 89. DATE OF OPERATION   |                                  | 90. MAJOR FINDINGS OF OPERATION   |  |
| 91. DATE OF OPERATION   |                                  | 92. MAJOR FINDINGS OF OPERATION   |  |
| 93. DATE OF OPERATION   |                                  | 94. MAJOR FINDINGS OF OPERATION   |  |
| 95. DATE OF OPERATION   |                                  | 96. MAJOR FINDINGS OF OPERATION   |  |
| 97. DATE OF OPERATION   |                                  | 98. MAJOR FINDINGS OF OPERATION   |  |
| 99. DATE OF OPERATION   |                                  | 100. MAJOR FINDINGS OF OPERATION  |  |

CERTIFICATE OF DEATH

(Print Name)

DEPARTMENT OF HEALTH - BUREAU OF VITALS

Blank form with horizontal lines for text entry.



4-635

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6724

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HERBERT M. HARTMAN</b>   |                                  | 2. DATE OF DEATH <b>7-22-53</b>  |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTO. CITY</b> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>MERCY HOSP., INC.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 4</b>                                     |  |
| 6. Length of stay in Baltimore <b>LIFE</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>8203 LOCH RAVEN BLVD.</b>  |  |
| 7. SEX<br><b>MALE</b>  | 8. COLOR OR RACE<br><b>WHITE</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>  | 10. DATE OF BIRTH<br><b>SEPT. 26, 1883</b> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SELF EMPLOYED</b>   |                                  | 12. AGE (In years last birthday) <b>69</b>   |  |
| 13. FATHER'S NAME<br><b>AUGUSTUS HARTMAN</b>   |                                  | 14. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>UNKNOWN</b>  |                                  | 16. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 17. SOCIAL SECURITY NO.<br><b>218-07-9193</b>  |                                  | 18. MOTHER'S MAIDEN NAME<br><b>CATHERINE SHERTZER</b>  |  |
| 19. INFORMANT<br><b>H.M. HARTMAN (MED. CHART)</b>  |                                  | 20. ADDRESS<br><b>ABOVE</b>  |  |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>POST OPERATIVE SHOCK</b>   |                                  | 22. INTERVAL BETWEEN ONSET AND DEATH<br><b>4 HR 30M</b>  |  |
| 23. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>RESECTION RT. UPPER LOBE</b>  |                                  | 24. DUE TO<br><b>BRONCHOGENIC CARCINOMA 3MO. +</b>   |  |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>POSSIBLE CORONARY INSUFFICIENCY</b>  |                                  |  |  |
| 26. DATE OF OPERATION<br><b>7-22-53</b>  |                                  | 27. MAJOR FINDINGS OF OPERATION<br><b>BRONCHOGENIC CARCINOMA WITH METASTASIS</b>   |  |
| 28. DATE OF AUTOPSY<br><b>YES</b>  |                                  | 29. DATE OF AUTOPSY<br><b>NO</b>   |  |
| 30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                                  | 31. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/>                   |  |
| 32. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                                  | 33. HOW DID INJURY OCCUR?  |  |
| 34. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  |
| 36. I hereby certify that I attended the deceased from <b>7-21</b> , 19 <b>53</b> to <b>7-22</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7-22</b> , 19 <b>53</b> , and that death occurred at <b>4:35 p.m.</b> , from the causes and on the date stated above. |                                  |  |  |
| 37. SIGNATURE<br><b>Charles F. Carroll, Jr.</b>  |                                  | 38. ADDRESS<br><b>Mercy Hospital.</b>  |  |
| 39. DATE SIGNED<br><b>7-22-53</b>  |                                  |  |  |
| 40. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 41. DATE<br><b>7/25/53</b>   |  |
| 42. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>   |                                  | 43. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b>   |  |
| 44. RECEIVED BY<br><b>Jul 24 1953</b>  |                                  | 45. REGISTRAR'S SIGNATURE<br><b>Huntington</b>   |  |
| 46. FUNERAL DIRECTOR<br><b>2903L</b>   |                                  | 47. ADDRESS<br><b>Balto 17, Md.</b>  |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DEATH CERTIFICATE

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister of Religion

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

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6725

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6725

IRTH NO.

NAME OF DECEASED  
(Please Print)

LENA M. EBBERTS.

2. DATE  
OF  
DEATH

July 23 53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
STITUTION

Lutheran Hospital of Maryland

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

m.

A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

FATHER'S NAME

John G. Geiger

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

William M. Ebberts sr.

ADDRESS

Same

18. 260 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral Thrombosis  
DUE TO after amputation of left leg.

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Atherosclerotic Vascular disease  
DUE TO E.A.S.H.P.(C) Diabetes mellitus + retino  
-pathy. 20 yrsOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION // 19B. MAJOR FINDINGS OF OPERATION

July 9 53, July 21 53

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from July 21, 1953, to July 23, 1953, that I last saw the  
deceased alive on July 23, 1953, and that death occurred at 6 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Flora E. Geiger

M. D.

23B. ADDRESS

130 Edgemoor Rd.  
Luth. Hosp. of Maryland

23C. DATE SIGNED

7/23 1953

A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Glen Burnie, Md

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Brace Nabb &amp; Son

ADDRESS

7208A Catonsville, Md

VS 150

100

RECEIVED  
OFFICE OF THE  
SHERIFF

THE  
SHERIFF  
OF  
THE  
COUNTY  
OF  
SANTA  
BARBARA  
CALIFORNIA  
DO  
HEREBY  
CERTIFY  
THAT  
THE  
FOLLOWING  
PERSONS  
WAS  
ARRESTED  
ON  
THE  
[DATE]  
AT  
[LOCATION]  
BY  
[NAME]  
ON  
A  
CHARGE  
OF  
[CRIME]

- 245

3 6726

*McClinton*  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6726

NAME OF DECEASED  
(Last name or Print)PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

1700 N. Milton Ave

Length of stay in Baltimore Life

SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Internal Revenue 10B. KIND OF BUSINESS OR INDUSTRY

FATHER'S NAME John McClinton

WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No or unknown 16. SOCIAL SECURITY NO.

17. INFORMANT Address

Miss Mary McClinton 1700 N. Milton Ave

8. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 July, 1953, to 22 July, 1953, that I last saw the deceased alive on 22 July, 1953, and that death occurred at 6 A.M., from the causes and on the date stated above.

23A. SIGNATURE M. D. 23B. ADDRESS 1700 N. Milton Ave

23C. DATE SIGNED 23 July 53

BURIAL, CREMATION, REMOVAL (Specify) 24A. DATE July 25, 1953

24C. NAME OF CEMETERY OR CREMATORY New Leatherside

24D. LOCATION (City, town, or county) (State) Edmondson Ave

RECEIVED BY REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS Leach Leach 1701-03 N. Patterson Ave

VS 150 39091

STATE OF NEW YORK  
CERTIFICATE OF DEATH

6-22

|                             |  |                               |  |
|-----------------------------|--|-------------------------------|--|
| Name of Deceased            |  | Date of Death                 |  |
| Place of Birth              |  | Date of Birth                 |  |
| Sex                         |  | Race                          |  |
| Marital Status              |  | Cause of Death                |  |
| Occupation                  |  | Place of Death                |  |
| Signature of Physician      |  | Signature of Registrar        |  |
| Signature of Coroner        |  | Signature of Medical Examiner |  |
| Signature of Burial Officer |  | Signature of Cemetery         |  |
| Signature of Funeral Home   |  | Signature of Undertaker       |  |
| Signature of Family         |  | Signature of Friends          |  |
| Signature of Church         |  | Signature of Community        |  |
| Signature of State          |  | Signature of Nation           |  |



T-250

53 6727

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6727

|  |                                 |  |  |   |   |
|--|---------------------------------|--|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Clarence Malvern Tibbs</i>   |                                 |  | 2. DATE OF DEATH <i>July 23, 1953</i>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                 |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>16-01</i> |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <i>716 N. Carrollton Ave.</i>  |                                 |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>  |   |   |
| c. Length of stay in Baltimore <i>71 yrs.</i>  |                                 |  | D. STREET ADDRESS (If rural, give location) <i>716 N. Carrollton Ave.</i>  |   |   |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>   | 8. DATE OF BIRTH <i>May 19, 1881</i>   |   | 9. AGE (in years last birthday) <i>72</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>  |                                 | 10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>  | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>  |   | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |
| 13. FATHER'S NAME <i>Charles Henry Tibbs</i>   |                                 |  | 14. MOTHER'S MAIDEN NAME <i>Mary E. Esalloway</i>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>   |                                 | 16. SOCIAL SECURITY NO. <i>150-10-10000</i>  |  | 17. INFORMANT <i>Mrs. Fannie L. Tibbs</i> ADDRESS <i>716 N. Carrollton Ave.</i> |   |
| 18. <i>443X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>hypertensive arterio-sclerotic cardiac disease</i> |                                 |  | INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                 |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                           |   |   |
| 19A. DATE OF OPERATION <i>7/23</i>   |                                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II          |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?        |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                 | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>7/14</i> , 19 <i>48</i> to <i>7.23</i> , 19 <i>53</i> that I last saw the deceased alive on <i>7/23</i> , 19 <i>53</i> and death occurred at <i>7:03</i> p.m., from the causes and on the date stated above.       |                                 |  |  |   |   |
| 23A. SIGNATURE <i>[Signature]</i>  |                                 |  |  | 23C. DATE SIGNED <i>7.24.53</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                                 | 24B. DATE <i>July 27, 1953</i>   |  | 24C. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>             |   |
| DATE RECEIVED BY LOCAL REGISTRAR <i>July 24, 1953</i>  |                                 | REGISTRAR'S SIGNATURE <i>Huntington Williams</i>   |  | 25. GENERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>                             |   |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

79-263  
53 6728BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6728

TH NO.

NAME OF DECEASED  
(Type or Print)

Theressa Wilson Richardson

2. DATE  
OF  
DEATH

July 21, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1016 N. Woodyear St.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

16-02

D. STREET ADDRESS (If rural, give location)

1016 N. Woodyear St.

SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

July 4, 1883

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

E. Richardson G. Cornish 1016 N.

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Woodyear St.

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

7

7

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-10, 1953, to 7-22, 1953, that I last saw the  
deceased alive on 7-22, 1953, and that death occurred at 1059 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

FEE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presstman St.

VS. 150

Geo. G. Kelson

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

NOTIFICATION OF DEATH

|                                       |  |  |  |
|---------------------------------------|--|--|--|
| 1. Name of deceased                   |  | 2. Date of death                           |  |
| 3. Sex                                |  | 4. Age                                     |  |
| 5. Race                               |  | 6. Marital status                          |  |
| 7. Usual residence                    |  | 8. Place of death                          |  |
| 9. Cause of death                     |  | 10. Manner of death                        |  |
| 11. Physician's name                  |  | 12. Signature of physician                 |  |
| 13. Signature of informant            |  | 14. Date of notification                   |  |
| 15. Name of funeral home              |  | 16. Signature of funeral home              |  |
| 17. Name of next of kin               |  | 18. Signature of next of kin               |  |
| 19. Name of coroner                   |  | 20. Signature of coroner                   |  |
| 21. Name of registrar                 |  | 22. Signature of registrar                 |  |
| 23. Name of medical examiner          |  | 24. Signature of medical examiner          |  |
| 25. Name of health officer            |  | 26. Signature of health officer            |  |
| 27. Name of local health department   |  | 28. Signature of local health department   |  |
| 29. Name of state health department   |  | 30. Signature of state health department   |  |
| 31. Name of federal health department |  | 32. Signature of federal health department |  |
| 33. Name of other health department   |  | 34. Signature of other health department   |  |
| 35. Name of other health department   |  | 36. Signature of other health department   |  |
| 37. Name of other health department   |  | 38. Signature of other health department   |  |
| 39. Name of other health department   |  | 40. Signature of other health department   |  |
| 41. Name of other health department   |  | 42. Signature of other health department   |  |
| 43. Name of other health department   |  | 44. Signature of other health department   |  |
| 45. Name of other health department   |  | 46. Signature of other health department   |  |
| 47. Name of other health department   |  | 48. Signature of other health department   |  |
| 49. Name of other health department   |  | 50. Signature of other health department   |  |
| 51. Name of other health department   |  | 52. Signature of other health department   |  |
| 53. Name of other health department   |  | 54. Signature of other health department   |  |
| 55. Name of other health department   |  | 56. Signature of other health department   |  |
| 57. Name of other health department   |  | 58. Signature of other health department   |  |
| 59. Name of other health department   |  | 60. Signature of other health department   |  |
| 61. Name of other health department   |  | 62. Signature of other health department   |  |
| 63. Name of other health department   |  | 64. Signature of other health department   |  |
| 65. Name of other health department   |  | 66. Signature of other health department   |  |
| 67. Name of other health department   |  | 68. Signature of other health department   |  |
| 69. Name of other health department   |  | 70. Signature of other health department   |  |
| 71. Name of other health department   |  | 72. Signature of other health department   |  |
| 73. Name of other health department   |  | 74. Signature of other health department   |  |
| 75. Name of other health department   |  | 76. Signature of other health department   |  |
| 77. Name of other health department   |  | 78. Signature of other health department   |  |
| 79. Name of other health department   |  | 80. Signature of other health department   |  |
| 81. Name of other health department   |  | 82. Signature of other health department   |  |
| 83. Name of other health department   |  | 84. Signature of other health department   |  |
| 85. Name of other health department   |  | 86. Signature of other health department   |  |
| 87. Name of other health department   |  | 88. Signature of other health department   |  |
| 89. Name of other health department   |  | 90. Signature of other health department   |  |
| 91. Name of other health department   |  | 92. Signature of other health department   |  |
| 93. Name of other health department   |  | 94. Signature of other health department   |  |
| 95. Name of other health department   |  | 96. Signature of other health department   |  |
| 97. Name of other health department   |  | 98. Signature of other health department   |  |
| 99. Name of other health department   |  | 100. Signature of other health department  |  |

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6729  
Registered No. \_\_\_\_\_BIRTH NO. 53-247741. NAME OF DECEASED  
(Type or Print)

BABY BOY GREER

2. DATE  
OF  
DEATH

JUNE 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland yesB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

ST. AGNES HOSPITAL

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 23, Md.

D. STREET ADDRESS (If rural, give location)

1414 McHenry Street

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July one 28, 53

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

13

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Kathleen ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

253 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Blue Asphyxia  
Myxedema.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1953, to June 28, 1953, that I last saw the  
deceased alive on June 28, 1953, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Blanch Ochoa, M.D.

23B. ADDRESS

St. Agnes' Hospital

23C. DATE SIGNED

July 15 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

7/24/53

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town or county) / (State)

Baltimore

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

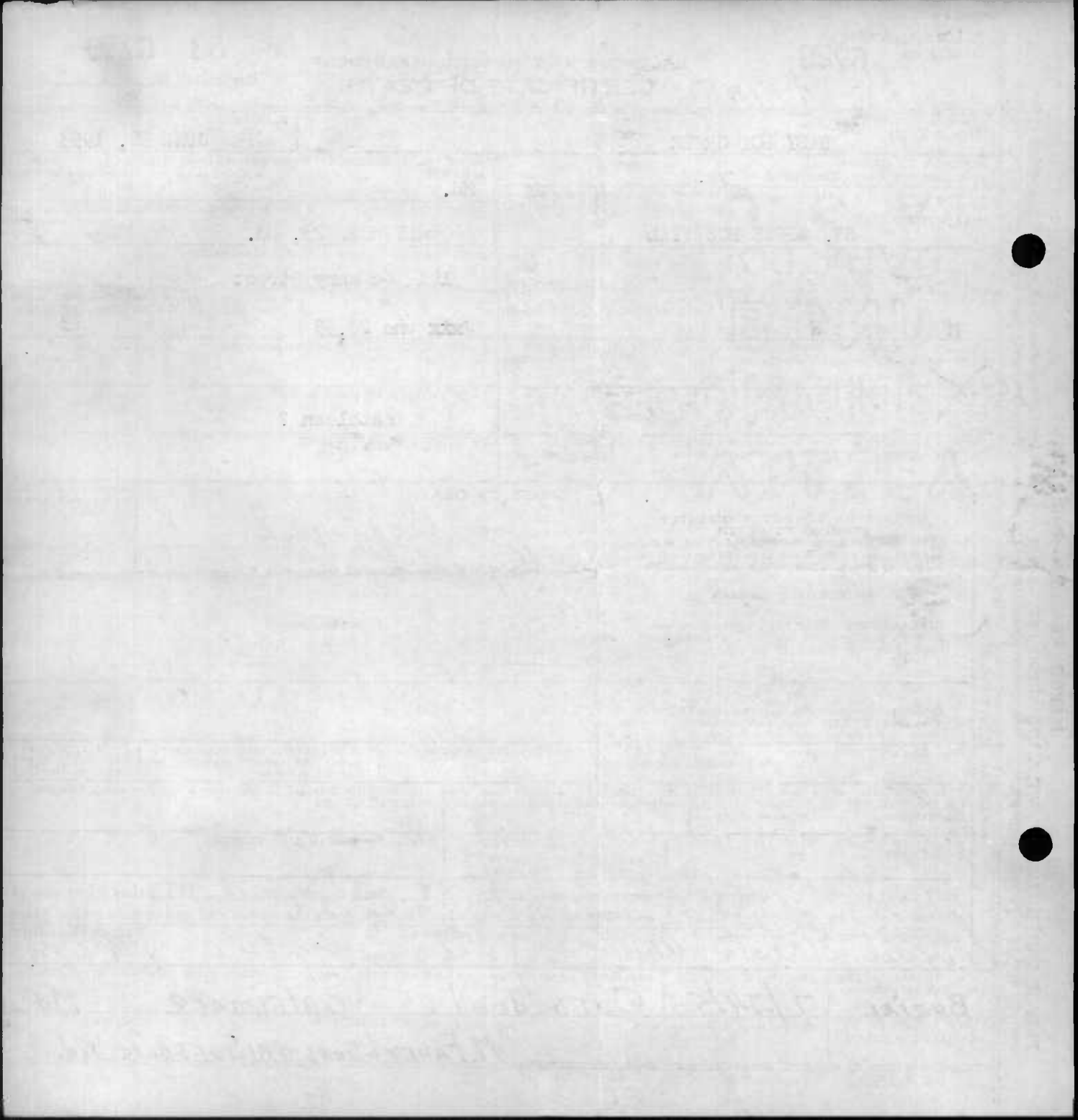
Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

M. FAHEY &amp; SONS 4015 SUFFOLK RD.

JUL 24 1953





Y-426  
53 6730BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6730  
Registered No.

TH NO.

|  |  |   |   |
|--|--|---|---|
| NAME OF DECEASED<br>(Last, first, middle or Print)   |  | 2. DATE OF DEATH  |   |
| ABRAHAM M. KRIEGER   |  | 7-23-53   |   |
| PLACE OF DEATH<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |   |
| 1105 E. Fayette St   |  | A. STATE Md   |   |
| FULL NAME OF DECEASED<br>(If not in hospital or institution, give street address or location)  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |   |
| Fayette Home   |  | Baltimore 27-16   |   |
| Length of stay in Baltimore  |  | D. STREET ADDRESS (If rural, give location)   |   |
| 65 Yrs. 65 Mos. 65 Days  |  | 3114 Oakford Ave  |   |
| SEX  | 6. COLOR OR RACE   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                       | 8. DATE OF BIRTH                              |
| Male   | White  | married   | 70  |
| 9. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)   |  | 10a. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)     |
| Merchant   |  | Milinery  | Russia  |
| FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |   |
| Not known  |  | Not known   |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS                         |
| no or unknown  |  | 064 05-2143A  | Rose Krieger - Same                           |
| 18. CAUSE OF DEATH   |  |   | INTERVAL BETWEEN ONSET AND DEATH              |
| 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Cerebral Hemorrhage<br>(A) DUE TO |  |   | 72 hrs.                                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C)  |  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |   |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 0  |  |   |   |
| 20. AUTOPSY?   |  |   |   |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |
|  |  |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?  |   |
|  |  |   |   |
| 22. I hereby certify that I attended the deceased from 22 July 1953, to 23 July 1953 that I last saw the deceased alive on 23 July 1953, and that death occurred at 7:05 p. m., from the causes and on the date stated above.                  |  |   |   |
| 23A. SIGNATURE   |  | 23B. ADDRESS  | 23C. DATE SIGNED                              |
| [Signature]  |  | 2020 N. Charles St  | 24 July 53                                    |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE  | 24C. NAME OF CEMETERY OR CREMATORY  | 24D. LOCATION (City, town, or county) (State) |
| Funeral  | 7-26-53  | Baltimore Hebrew  | Balto, Md                                     |
| RECEIVED BY CAL REGISTRAR  | REGISTRAR'S SIGNATURE  | 25. FUNERAL DIRECTOR  | ADDRESS                                       |
| 06-24-1953   | Huntington Williams  | Michael Lewis   | 2100 Guiton Pl                                |

2906E

Dr De Hoff  
2020110 Charles St  
8:30 AM

---

-536

53 6731

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6731  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

Mr. Oshen Linder

2. DATE  
OF  
DEATH

7/24/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

Doctor's Hospital  
2724 N. Charles St.HOSPITAL OR  
INSTITUTION

Length of stay in Baltimore

13 Yrs.  
Mon.  
Days

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR  
INDUSTRY

Drooms

FATHER'S NAME

Not Known

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

67

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Not Known

17. INFORMANT

ADDRESS

Ma Linder - Home

I. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary thromboses

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Pulmonary edema

(C) DUE TO

Emphysema. Myo-  
carditis & fibrosis.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21, 1953, to 7/24, 1953, that I last saw the  
deceased alive on 7/23, 1953, and that death occurred at 9:55 a. m., from the causes and on the date stated above.

23. SIGNATURE

Maurice Shidoo, M.D.

23B. ADDRESS

2225 Linden Ave

23C. DATE SIGNED

7/24/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-24-53

24C. NAME OF CEMETERY OR CREMATORY

Herring Hill

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Hewitt

ADDRESS

2100 Canton Pl

VS 150

29032

INDEPENDENT CITY HEALTH DEPT.  
CERTIFICATE OF DEATH

|                         |  |                       |  |                           |  |                       |  |                       |  |
|-------------------------|--|-----------------------|--|---------------------------|--|-----------------------|--|-----------------------|--|
| Name of Deceased        |  | Age                   |  | Sex                       |  | Race                  |  | Color                 |  |
| Date of Death           |  | Time of Death         |  | Place of Death            |  | Cause of Death        |  | Manner of Death       |  |
| Signature of Physician  |  | Signature of Coroner  |  | Signature of Registrar    |  | Signature of Witness  |  | Signature of Deceased |  |
| Signature of Family     |  | Signature of Friend   |  | Signature of Neighbor     |  | Signature of Minister |  | Signature of Priest   |  |
| Signature of Undertaker |  | Signature of Embalmer |  | Signature of Funeral Home |  | Signature of Cemetery |  | Signature of Burial   |  |

MARGIN RESERVED FOR BINDING

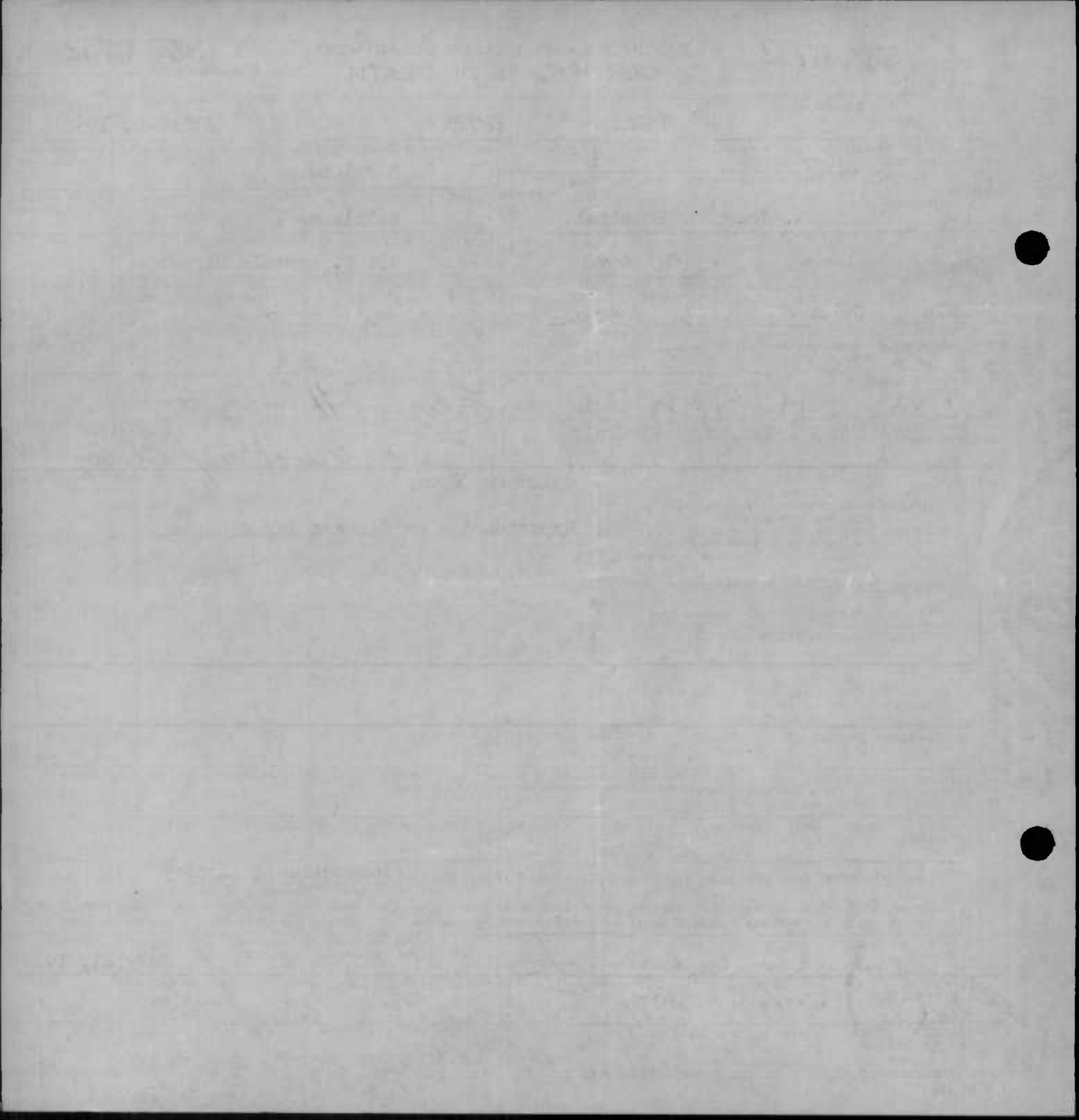
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650  
53 6732

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6732  
Registered No.

|   |                                     |   |  |   |  |
|---|-------------------------------------|---|--|---|--|
| BIRTH NO.   |                                     | FRANCES BROWN   |  | 2. DATE OF DEATH<br>July 20, 1953   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                                     |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)           |  |
|   |                                     |   |  | A. STATE<br>Maryland  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                     |   |  | B. COUNTY   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>St. Joseph's Hospital  |                                     |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 12-05 |  |
| c. Length of stay in Baltimore<br>50 yrs  |                                     |   |  | D. STREET ADDRESS (If rural, give location)<br>331 E. Lanvale Street                            |  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>Colored         | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow  | 8. DATE OF BIRTH<br>2/28/93                                  | 9. AGE (In years last birthday)<br>60   | If Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None   |                                     | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br>Virginia        |   | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br>William H. Scott   |                                     |   | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Scott                  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br>George Quickley Cherry Hill                 |   |  |
| 18. 443X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive cardiovascular disease<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION  |                                     | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                        |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                     | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .   |                                     |   |  |   |  |
| 23A. SIGNATURE<br>Joseph A. Jachimczyk M.D.   |                                     | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br>July 21, 1953   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 24B. DATE<br>7/25/53                | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary Cem  | 24D. LOCATION (City, town, or county) (State)<br>A. A. G. Md |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br>Huntington | 25. FUNERAL DIRECTOR<br>Rayner Sanders  |  | ADDRESS<br>217 E. Preston St  |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. If you need more space, use the back of this form. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

|  |                             |   |  |  |                                       |
|--|-----------------------------|---|--|--|---------------------------------------|
| W-452<br>53 6733   |                             | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 53 6733<br>Registered No. _____  |                                       |
| BIRTH NO. _____  |                             |   |  |  |                                       |
| 1. NAME OF DECEASED<br>(Type or Print) Mary E. Williams  |                             |   |  | 2. DATE OF DEATH<br>7/24/53  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY _____ |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>1606 N. Monroe Street   |                             |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-02                            |                                       |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                             |   |  | D. STREET ADDRESS (If rural, give location)<br>1606 N. Monroe Street   |                                       |
| 5. SEX<br>F  | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married  |  | 8. DATE OF BIRTH<br>Sept. 6, 1911  | 9. AGE (In years last birthday)<br>41 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Labor   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>Western Electric   |  | 11. BIRTHPLACE (State or foreign country)<br>N. C.   |                                       |
| 13. FATHER'S NAME<br>Levi Bonds  |                             |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>_____  |                                       |
| 14. MOTHER'S MAIDEN NAME<br>Feldia Wooden  |                             |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) _____   |                                       |
| 16. SOCIAL SECURITY NO.<br>214-16-8180   |                             |   |  | 17. INFORMANT<br>Herman Williams   |                                       |
| 18. 155 X 1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Primary Cancer of Liver<br>DUE TO<br>(B) Carcinomatosis + Respiratory Failure<br>DUE TO<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br>3 months |                             |   |  | ADDRESS<br>1606 N. Monroe St   |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____   |                             |   |  |  |                                       |
| 19A. DATE OF OPERATION<br>6-19-53  |                             | 19B. MAJOR FINDINGS OF OPERATION<br>Primary Cancer of Liver   |  |  |                                       |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |   |  |  |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                             | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                             | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |                                       |
| 22. I hereby certify that I attended the deceased from 4-30-53, 1953, to 7-24-1953, that I last saw the deceased alive on 7-24-1953, and that death occurred at 6 A. M., from the causes and on the date stated above.   |                             |   |  |  |                                       |
| 23A. SIGNATURE<br>H. S. Phillips   |                             | 23B. ADDRESS<br>2224 Madison Ave.   |  | 23C. DATE SIGNED<br>7-24-53  |                                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                             | 24B. DATE<br>7/27/53  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary  |                                       |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland   |                             | 24E. FUNERAL DIRECTOR<br>Arlington S. Phillips 1808 N. Monroe St.   |  |  |                                       |
| DATE RECEIVED BY LOCAL REGISTRAR   |                             | REGISTRAR'S SIGNATURE<br>Huntington Williams  |  | ADDRESS  |                                       |

STATE OF NEW YORK  
CERTIFICATE OF DEATH

|                                   |  |                                     |  |                                       |  |
|-----------------------------------|--|-------------------------------------|--|---------------------------------------|--|
| 1. Name of deceased               |  | 2. Sex                              |  | 3. Age                                |  |
| 4. Date of death                  |  | 5. Time of death                    |  | 6. Place of death                     |  |
| 7. Cause of death                 |  | 8. Manner of death                  |  | 9. Signature of physician             |  |
| 10. Signature of registrar        |  | 11. Signature of informant          |  | 12. Signature of witness              |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker         |  | 15. Signature of cemetery             |  |
| 16. Signature of health officer   |  | 17. Signature of coroner            |  | 18. Signature of justice of the peace |  |
| 19. Signature of town clerk       |  | 20. Signature of village clerk      |  | 21. Signature of city clerk           |  |
| 22. Signature of county clerk     |  | 23. Signature of state clerk        |  | 24. Signature of federal clerk        |  |
| 25. Signature of postmaster       |  | 26. Signature of telegraph operator |  | 27. Signature of telephone operator   |  |
| 28. Signature of newspaper editor |  | 29. Signature of publisher          |  | 30. Signature of printer              |  |
| 31. Signature of compositor       |  | 32. Signature of binder             |  | 33. Signature of distributor          |  |
| 34. Signature of carrier          |  | 35. Signature of collector          |  | 36. Signature of agent                |  |
| 37. Signature of broker           |  | 38. Signature of dealer             |  | 39. Signature of merchant             |  |
| 40. Signature of manufacturer     |  | 41. Signature of wholesaler         |  | 42. Signature of retailer             |  |
| 43. Signature of importer         |  | 44. Signature of exporter           |  | 45. Signature of shipper              |  |
| 46. Signature of receiver         |  | 47. Signature of consignee          |  | 48. Signature of consignee            |  |
| 49. Signature of consignee        |  | 50. Signature of consignee          |  | 51. Signature of consignee            |  |
| 52. Signature of consignee        |  | 53. Signature of consignee          |  | 54. Signature of consignee            |  |
| 55. Signature of consignee        |  | 56. Signature of consignee          |  | 57. Signature of consignee            |  |
| 58. Signature of consignee        |  | 59. Signature of consignee          |  | 60. Signature of consignee            |  |
| 61. Signature of consignee        |  | 62. Signature of consignee          |  | 63. Signature of consignee            |  |
| 64. Signature of consignee        |  | 65. Signature of consignee          |  | 66. Signature of consignee            |  |
| 67. Signature of consignee        |  | 68. Signature of consignee          |  | 69. Signature of consignee            |  |
| 70. Signature of consignee        |  | 71. Signature of consignee          |  | 72. Signature of consignee            |  |
| 73. Signature of consignee        |  | 74. Signature of consignee          |  | 75. Signature of consignee            |  |
| 76. Signature of consignee        |  | 77. Signature of consignee          |  | 78. Signature of consignee            |  |
| 79. Signature of consignee        |  | 80. Signature of consignee          |  | 81. Signature of consignee            |  |
| 82. Signature of consignee        |  | 83. Signature of consignee          |  | 84. Signature of consignee            |  |
| 85. Signature of consignee        |  | 86. Signature of consignee          |  | 87. Signature of consignee            |  |
| 88. Signature of consignee        |  | 89. Signature of consignee          |  | 90. Signature of consignee            |  |
| 91. Signature of consignee        |  | 92. Signature of consignee          |  | 93. Signature of consignee            |  |
| 94. Signature of consignee        |  | 95. Signature of consignee          |  | 96. Signature of consignee            |  |
| 97. Signature of consignee        |  | 98. Signature of consignee          |  | 99. Signature of consignee            |  |
| 100. Signature of consignee       |  | 101. Signature of consignee         |  | 102. Signature of consignee           |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|   |  |                                  |   |                |  |
|---|--|----------------------------------|---|----------------|--|
| H 610   |  | BALTIMORE CITY HEALTH DEPARTMENT |   | 53 6734        |  |
| BIRTH NO.   |  | CERTIFICATE OF DEATH             |   | Registered No. |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |                                  | 2. DATE OF DEATH  |                |  |
| Sarah E. Harvey   |  |                                  | July 23, 1953   |                |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)     |                |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |  |                                  | A. STATE  |                |  |
| 2334 Annapolis Road   |  |                                  | Md.   |                |  |
| C. Length of stay in Baltimore  |  |                                  | C. CITY OR TOWN   |                |  |
| Yrs. Mos. Days  |  |                                  | Balto. 25-33 W.   |                |  |
| 5. SEX  |  |                                  | D. STREET ADDRESS (If rural, give location)   |                |  |
| female  |  |                                  | 2334 Annapolis Rd   |                |  |
| 6. COLOR OR RACE  |  |                                  | E. DATE OF BIRTH  |                |  |
| white   |  |                                  | 11/28/1875  |                |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |  |                                  | F. AGE (In years last birthday)   |                |  |
| Widowed   |  |                                  | 77  |                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                                  | 11. BIRTHPLACE (State or foreign country)   |                |  |
| At Home   |  |                                  | Balto. Md.  |                |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |                |  |
| Self  |  |                                  |   |                |  |
| 13. FATHER'S NAME   |  |                                  | 14. MOTHER'S MAIDEN NAME  |                |  |
| Moses Deaver  |  |                                  | Laura Duwall  |                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |  |                                  | 16. SOCIAL SECURITY NO.   |                |  |
| No  |  |                                  |   |                |  |
| 17. INFORMANT   |  |                                  | ADDRESS   |                |  |
| Alma Norris   |  |                                  | 2334 Annapolis Rd   |                |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                     |  |                                  | CAUSE OF DEATH  |                |  |
| 443x  |  |                                  | Cerebral Hemorrhage   |                |  |
| 19. ANTECEDENT CAUSES   |  |                                  | Hypertensive C. V. D.   |                |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |                                  | Interval Between Onset and Death  |                |  |
| II  |  |                                  | 1 day   |                |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  | 7 years   |                |  |
| 19A. DATE OF OPERATION  |  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                |  |
| 0   |  |                                  |   |                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |                |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |                                  | 20. AUTOPSY?  |                |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |                |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                                  | 21F. HOW DID INJURY OCCUR?  |                |  |
| 22. I hereby certify that I attended the deceased from June 1946 to July 23, 1953, that I last saw the deceased alive on July 19, 1953, and that death occurred at 2A m., from the causes and on the date stated above. |  |                                  |   |                |  |
| 23A. SIGNATURE  |  |                                  | 23B. ADDRESS  |                |  |
| Paul Schmied  |  |                                  | 7301 Annapolis Rd   |                |  |
| 23C. DATE SIGNED  |  |                                  | 7/23/53   |                |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  |                                  | 24B. DATE   |                |  |
| Burial  |  |                                  | 7/25/53   |                |  |
| 24C. NAME OF CEMETERY OR CREMATORY  |  |                                  | 24D. LOCATION (City, town, or county)   |                |  |
| Mt. Olivet  |  |                                  | Balto. Md.  |                |  |
| 25. FUNERAL DIRECTOR  |  |                                  | ADDRESS   |                |  |
| Huntington Williams, M.D.   |  |                                  | 7217 St. Paul St.   |                |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  |                                  | REGISTRAR'S SIGNATURE   |                |  |
| 11/24/53  |  |                                  | Huntington Williams, M.D.   |                |  |



G-663  
53 6735BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6735

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Estelle N. Gerhardt

2. DATE  
OF  
DEATH

7/22/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1103 E. Payette St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto.

53-00

D. STREET ADDRESS (If rural, give location)

1101 Courtney Rd.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9/16/1877

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

London, England

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Walter H. Harrison

14. MOTHER'S MAIDEN NAME

Blanche Schmeigler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Estelle Fischer 1101 Courtney Rd.

18.

331X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchopneumonia

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

48 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

48 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 July, 1953, to 22 July, 1953, that I last saw the  
deceased alive on 22 July, 1953, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23. SIGNATURE

Blanche Schmeigler

23B. ADDRESS

2020 N Charles St

23C. DATE SIGNED

23 July 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/25/53

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

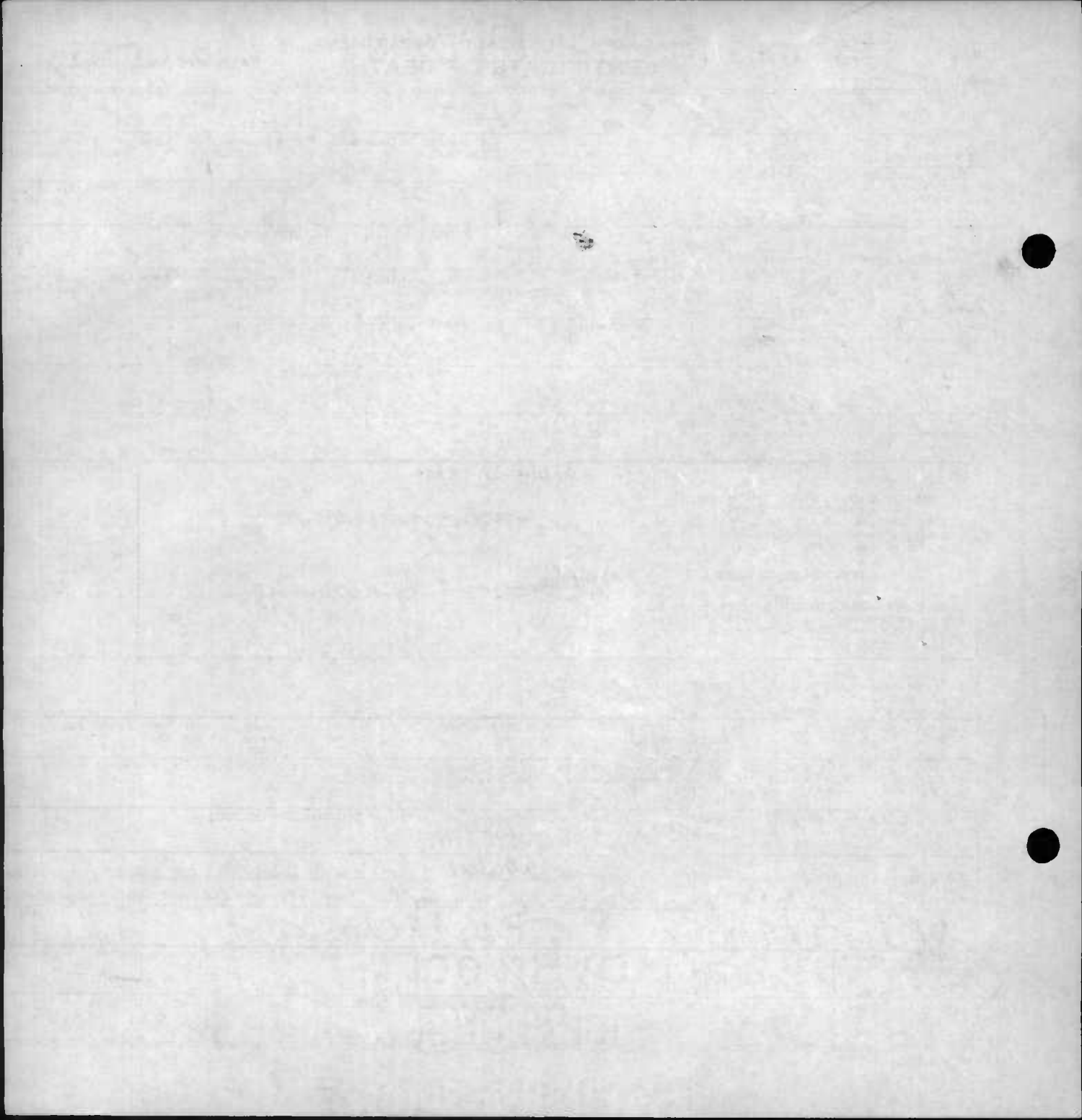
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Eck, Inc. 1217 St. Paul St.

ADDRESS





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

A-5363 6736

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6736  
Registered No.

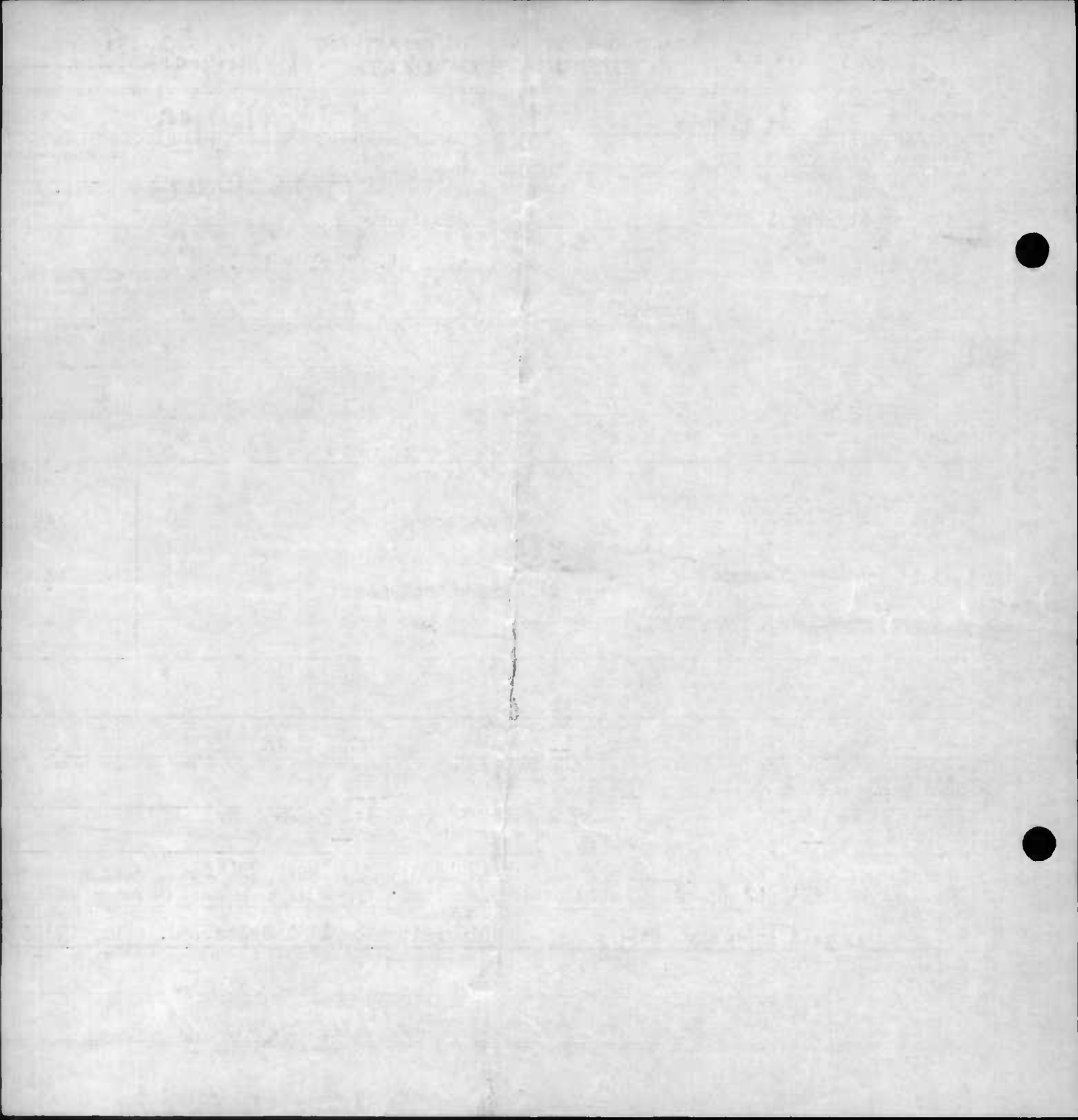
BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Odious Andrews</b>  |                                  | 2. DATE OF DEATH<br><b>July 23, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland.</b><br>B. COUNTY <b>27-18</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |
| C. Length of stay in Baltimore  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5222 St. Charles Ave., # 15</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>11/12/1905</b>        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Checker</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore Steel Works</b>  | 9. AGE (In years last birthday)<br><b>47</b> |
| 13. FATHER'S NAME<br><b>Charles Andrews</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Waters</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>                                      |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Lois Andrews</b>  |                                  | ADDRESS<br><b>5222 St. Charles Ave</b>   |  |

|   |   |  |  |
|---|---|--|--|
| 18. <b>190X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Melanosarcoma</b><br>DUE TO            |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs</b>                         |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) diffuse metastases</b><br>DUE TO   |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>none</b>   |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>May 12 '53</b> , 19__, to <b>July 23 '53</b> , 19__, that I last saw the deceased alive on <b>July 23</b> , 1953, and that death occurred at <b>11 A.</b> m., from the causes and on the date stated above. |   |  |  |
| 23A. SIGNATURE<br><b>Robert E. Bauer MD</b>   |   | 23B. ADDRESS<br><b>University Hospital Balto., Md.</b>                   | 23C. DATE SIGNED<br><b>July 23 '53</b>                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>7/25/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine</b>                    | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Co. Md.</b>   |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>William Williams</b>  | 25. FUNERAL DIRECTOR<br><b>Wm. Cook Inc.</b>                             | ADDRESS<br><b>1217 St. Paul St.</b>                                      |

VS 150

6903A



53 6737

53 6737

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 3698

BIRTH NO.

|   |                           |  |                                    |
|---|---------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>FRANK HENDERSON</b>   |                           | 2. DATE OF DEATH <b>7/22/53</b>  |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |                                    |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>62 7 PITCHER STREET</b>  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>BALTIMORE</b>                              |                                    |
| c. Length of stay in Baltimore <b>LIFE</b>  |                           | D. STREET ADDRESS (If rural, give location)<br><b>627 PITCHER ST.</b>  |                                    |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>C</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>   | 8. DATE OF BIRTH <b>11/25/1900</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b> |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>   |                                    |
| 13. FATHER'S NAME<br><b>JESSE HENDERSON</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>JANIE LOMAX</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>                                    |                           | 16. SOCIAL SECURITY NO. <b>220-09-6253</b>   |                                    |
| 17. INFORMANT <b>THELMA HENDERSON(D)</b>  |                           | ADDRESS <b>627 PITCHER ST.</b>   |                                    |

|  |  |                                  |
|--|--|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Carcinoma</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO   |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Angina</b>  |  |                                  |
| DUE TO   |  |                                  |
| DUE TO   |  |                                  |

|   |   |  |  |
|---|---|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                    |   |  |  |
| 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

|  |   |  |   |
|--|---|--|---|
| 22. I hereby certify that I attended the deceased from <b>5-28-1953</b> , to <b>7-22-1953</b> , that I last saw the deceased alive on <b>5-28-1953</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><b>Frank A. Saunders</b>   | 23B. ADDRESS<br><b>1029 N. Stricker St.</b> | 23C. DATE SIGNED<br><b>7-23-53</b>                           |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>7/25/53</b>                 | 24C. NAME OF CEMETERY OR CREMATORY<br><b>ACBURN CEMETERY</b> | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD</b> |

|                                  |  |   |                                    |
|----------------------------------|--|---|------------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE<br><b>Huntington</b> | 25. FUNERAL DIRECTOR<br><b>Charles H. Harte</b> | ADDRESS<br><b>512 Sweeten Ave.</b> |
|----------------------------------|--|---|------------------------------------|

VS 150

97024

512 Sweeten Ave.

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FRANK WHEATON

OS 7 FIFTH STREET

1900

11/10/00

WHEATON

WHEATON

WHEATON

WHEATON

WHEATON

WHEATON

WHEATON

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

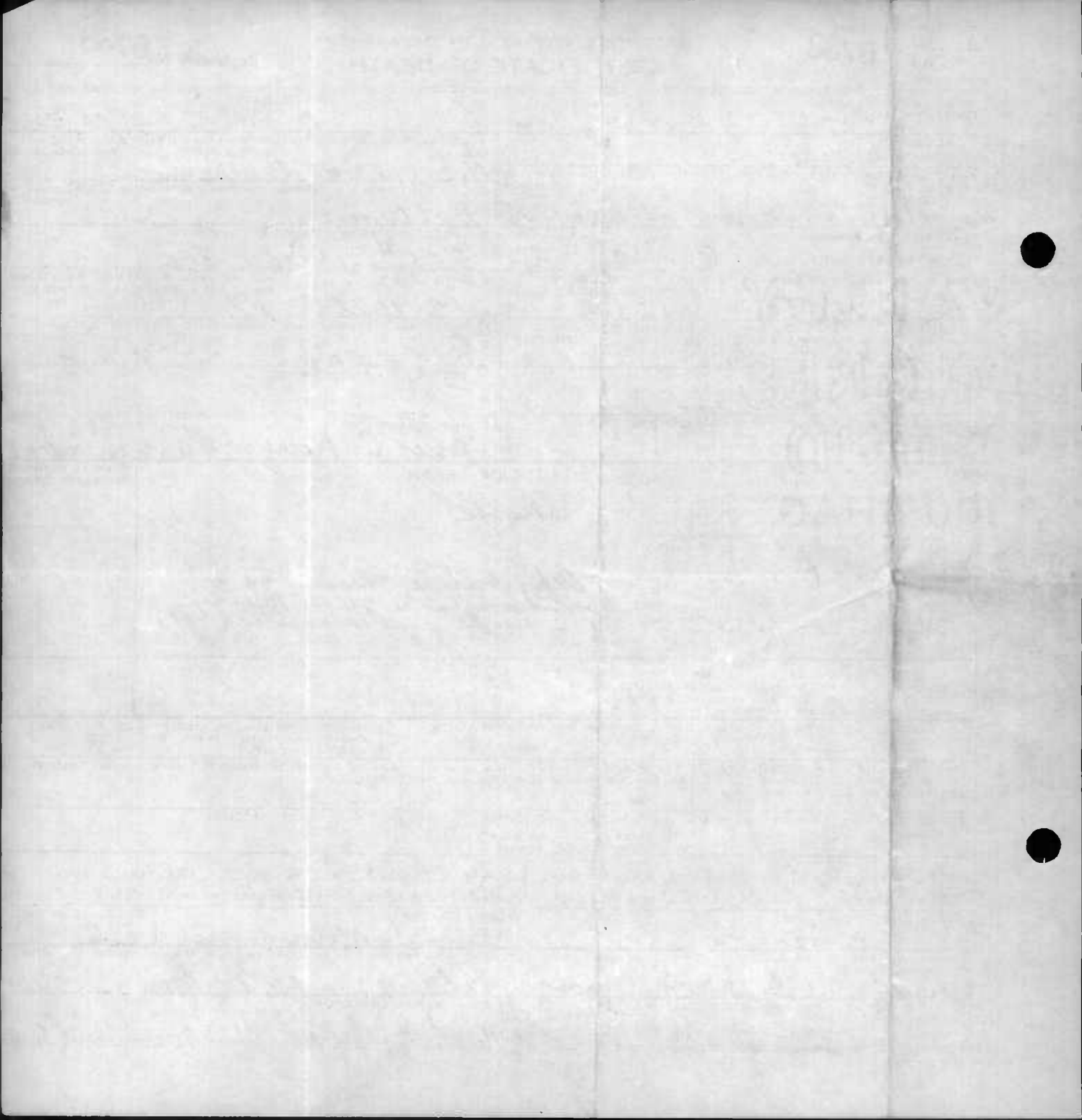
K-625-  
53 6738

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6738

BIRTH NO.

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Antonia Kurzmiller</u>  |                               | 2. DATE OF DEATH <u>7/21/53</u>  |   |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u>  |                               | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hospital for Women of Maryland</u>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>7-01</u>                                    |   |
| C. Length of stay in Baltimore <u>60 yrs.</u> Yrs. Mos. Days  |                               | D. STREET ADDRESS (If rural, give location) <u>505 N. E. Wood Ave.</u>   |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>   | 8. DATE OF BIRTH <u>10-10-78</u>          |
| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>   |                               | 9B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <u>74</u> |
| 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                               | 11. BIRTHPLACE (State or foreign country) <u>Germany</u>   |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                               | 13. FATHER'S NAME <u>Kreiner</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>?</u>   |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO. <u>-</u>  |                               | 17. INFORMANT <u>Louis C. Kurzmiller, Son</u> ADDRESS <u>8209</u>  |   |
| 18. <u>416X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                               | CAUSE OF DEATH   |   |
| DUE TO <u>Shock</u>   |                               | INTERVAL BETWEEN ONSET AND DEATH   |   |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                               | (B) <u>Acute intercurrent Rheumatism +</u>   |   |
| (C) <u>Intense chronic Heart Disease + acute pyelonephritis (left)</u>  |                               |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                               |  |   |
| 19A. DATE OF OPERATION <u>7/21/53</u>   |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                               | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR?  |                               | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>July 20, 1953</u> to <u>July</u> , 19 <u>53</u> that I last saw the deceased alive on <u>July 21, 1953</u> and that death occurred at <u>12:06 p.m.</u> , from the causes and on the date stated above. |                               |  |   |
| 23A. SIGNATURE <u>Blonday</u>   |                               | 23B. ADDRESS <u>Hospital for Women of Md.</u>  |   |
| 23C. DATE SIGNED <u>7-21-53</u>   |                               | 23D. LOCATION (City, town, or county) (State) <u>Baltimore</u>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 24B. DATE <u>July 20, 1953</u>   |   |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>  |                               | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>   |   |
| 25. FUNERAL DIRECTOR <u>Wendell J. Pippel</u>   |                               | ADDRESS <u>3125 Highland</u>   |   |





L-000  
53 6739  
53-15649

BALTIMORE CITY HEALTH DEPARTMENT

53 6739

CERTIFICATE OF DEATH

Registered No.

|  |                                  |  |                                     |
|--|----------------------------------|--|-------------------------------------|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><i>Reginald Eugene Lee</i>  |                                  | 2. DATE OF DEATH<br><i>July 20, 1953</i>   |                                     |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <i>md.</i><br>B. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto.</i><br>C. STREET ADDRESS (If rural, give location)<br><i>406 Pittman Pl.</i> |                                     |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Provident Hospital</i>  |                                  | 6. LENGTH OF STAY IN BALTIMORE<br><i>9</i> Yrs. <i>9</i> Mos. <i>9</i> Days  |                                     |
| 7. SEX<br><i>Male</i>  | 8. COLOR OR RACE<br><i>Negro</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 10. DATE OF BIRTH<br><i>7-12-53</i> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  |                                  | 12. AGE (in years last birthday)<br><i>9</i>   |                                     |
| 13. 10B. KIND OF BUSINESS OR INDUSTRY  |                                  | 14. BIRTHPLACE (State or foreign country)<br><i>Balto, md.</i>   |                                     |
| 15. FATHER'S NAME<br><i>John Armistead Lee</i>   |                                  | 16. CITIZEN OF WHAT COUNTRY?   |                                     |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                  | 18. 14. MOTHER'S MAIDEN NAME<br><i>Delores Cager</i>   |                                     |
| 19. 16. SOCIAL SECURITY NO.  |                                  | 20. 17. INFORMANT<br><i>Mother</i>   |                                     |
| 21. 8. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>776X I Prematurity</i><br>(A) DUE TO                     |                                  | 22. INTERVAL BETWEEN ONSET AND DEATH   |                                     |
| 23. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C) <i>5-1-53</i>  |                                  |  |                                     |
| 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |                                     |
| 25. 9A. DATE OF OPERATION<br><i>0</i>  |                                  | 26. 19B. MAJOR FINDINGS OF OPERATION   |                                     |
| 27. 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                     |
| 28. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                                  | 29. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     |
| 30. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |  |                                     |
| 31. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 32. 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                     |
| 33. 21F. HOW DID INJURY OCCUR?   |                                  |  |                                     |
| 34. 22. I hereby certify that I attended the deceased from <i>7-12</i> , 19 <i>53</i> , to <i>7-20</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7/20</i> , 19 <i>53</i> , and that death occurred at <i>3:32 p.m.</i> , from the causes and on the date stated above. |                                  |  |                                     |
| 35. 23A. SIGNATURE<br><i>Longoloz</i>  |                                  | 36. 23B. ADDRESS<br>M. D. <i>Provident Hospital</i>  |                                     |
| 37. 23C. DATE SIGNED<br><i>7/21/53</i>   |                                  |  |                                     |
| 38. 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 39. 24B. DATE<br><i>7/24/53</i>  |                                     |
| 40. 24C. NAME OF CEMETERY OR CREMATORY<br><i>mt Calvary Ct</i>   |                                  | 41. 24D. LOCATION (City, town, or county) (State)<br><i>G. A. Co. md</i>   |                                     |
| 42. 25. RECEIVED BY<br>REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>   |                                  | 43. 25. FUNERAL DIRECTOR<br><i>J. L. Brown &amp; Son</i>   |                                     |
| 44. ADDRESS<br><i>108 W Montgomery St</i>  |                                  |  |                                     |



D-616

53 6740

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

Enma Driven

2. DATE  
OF  
DEATH

7/23/1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF DECEASED  
(If not in hospital or institution, give street address or location)

504 N. Calhoun St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

504 N. Calhoun St.

Length of stay in Baltimore

EX 6. COLOR OR RACE

Male Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 11, 1899

9. AGE (In years  
last birthday)

54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hanover Co. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

Thomas Taylor

14. MOTHER'S MAIDEN NAME

Macio

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Helma Farrow

ADDRESS

504 N. Calhoun St.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK ☐ WHILE AT ☐ WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20-1953 to 7-23-1953, that I last saw the deceased alive on 7-22-1953, and that death occurred at 2:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Huntington

Mrs. Kate R. Williams 322 N. Schenck St.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

NEW YORK  
MAY 1910

NEW YORK  
MAY 1910

- 250  
53 6741BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6741  
Registered No.

TH NO.

NAME OF DECEASED  
(Please Print)

Robert Jackson

2. DATE  
OF  
DEATH

7/21/1953

PLACE OF DEATH:  
Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived before admission)  
A. STATE Md.  
B. COUNTY Balto.FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
1510 W. Lanvale St.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto. 16-02Length of stay in Baltimore  
Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)  
1510 W. Lanvale St.SEX Male  
6. COLOR OR RACE Col.7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married8. DATE OF BIRTH  
April 19, 18789. AGE (In years last birthday) 75  
If Under 1 Year Months Days  
If Under 24 Hours Hours Min.10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  
Fed Cap.10B. KIND OF BUSINESS OR INDUSTRY  
B & O R.R.11. BIRTHPLACE (State or foreign country)  
Essex Co. Va.12. CITIZEN OF WHAT COUNTRY?  
U.S.A.FATHER'S NAME  
Robert Jackson Sr.14. MOTHER'S MAIDEN NAME  
Mary P.WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Sadie Scott 1510 W. Lanvale St.18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
422.1  
Pulmonary Edema

(A) DUE TO

INTERVAL BETWEEN ONSET AND DEATH  
2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
arterio sclerotic cardio-vascular disease  
1947

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7.14.47, 19, to 7.21.1953, that I last saw the deceased alive on 7.20.1953 and that death occurred at 2:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE  
James M. Karr23B. ADDRESS  
M. D. 4001 V. Carverton Ave23C. DATE SIGNED  
7-23-53

A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE  
7/26/195324C. NAME OF CEMETERY OR CREMATORY  
Arbutus Memorial Arbutus24D. LOCATION (City, town, or county) (State)  
Md.RECEIVED BY REGISTRAR'S SIGNATURE  
H. J. Williams25. FUNERAL DIRECTOR  
Mrs. Katie P. WilliamsADDRESS  
322 N. Schroeder St.





W-452  
53 6742BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6742  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

Charles Williams

2. DATE  
OF  
DEATH

7/22/1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
SPITAL OR INSTITUTIONLincoln Memorial Hosp.  
27 N. Carey St.Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Male Col.

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

?

8. DATE OF BIRTH

Oct. 12, 1894

9. AGE (In years  
last birthday)

58

11. Under 1 Year  
Months Days

11-04

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. MOTHER'S MAIDEN NAME

Lillian ?

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Viola Brown 224 N. Amity St.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Chronic Vascular Ather

7 Mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Myocardial Failure

?

(C)

Hypertension

By Autopsy

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-16, 1952 to 7-22, 1953, that I last saw the  
deceased alive on 7-22, 1952, and that death occurred at 11:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles T. Williams M. D.

23B. ADDRESS

861 Ashbur Pl.

23C. DATE SIGNED

7-22-53

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

7/27/1953

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

25. FUNERAL DIRECTOR

REGISTERED SIGNATURE

Miss Kate R. Williams

25. FUNERAL DIRECTOR

Miss Kate R. Williams

ADDRESS

322 N. Schrock St.

WILLINGDON DIST. HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

|                                  |  |                              |  |                                 |  |                                      |  |                             |  |
|----------------------------------|--|------------------------------|--|---------------------------------|--|--------------------------------------|--|-----------------------------|--|
| 1. Name of Deceased              |  | 2. Sex                       |  | 3. Age                          |  | 4. Date of Birth                     |  | 5. Date of Death            |  |
| 6. Cause of Death                |  | 7. Place of Death            |  | 8. Occupation                   |  | 9. Marital Status                    |  | 10. Signature of Registrar  |  |
| 11. Signature of Medical Officer |  | 12. Signature of Coroner     |  | 13. Signature of Police Officer |  | 14. Signature of Health Officer      |  | 15. Signature of Registrar  |  |
| 16. Signature of Deceased        |  | 17. Signature of Next of Kin |  | 18. Signature of Burial Officer |  | 19. Signature of Crematorium Officer |  | 20. Signature of Registrar  |  |
| 21. Signature of Registrar       |  | 22. Signature of Registrar   |  | 23. Signature of Registrar      |  | 24. Signature of Registrar           |  | 25. Signature of Registrar  |  |
| 26. Signature of Registrar       |  | 27. Signature of Registrar   |  | 28. Signature of Registrar      |  | 29. Signature of Registrar           |  | 30. Signature of Registrar  |  |
| 31. Signature of Registrar       |  | 32. Signature of Registrar   |  | 33. Signature of Registrar      |  | 34. Signature of Registrar           |  | 35. Signature of Registrar  |  |
| 36. Signature of Registrar       |  | 37. Signature of Registrar   |  | 38. Signature of Registrar      |  | 39. Signature of Registrar           |  | 40. Signature of Registrar  |  |
| 41. Signature of Registrar       |  | 42. Signature of Registrar   |  | 43. Signature of Registrar      |  | 44. Signature of Registrar           |  | 45. Signature of Registrar  |  |
| 46. Signature of Registrar       |  | 47. Signature of Registrar   |  | 48. Signature of Registrar      |  | 49. Signature of Registrar           |  | 50. Signature of Registrar  |  |
| 51. Signature of Registrar       |  | 52. Signature of Registrar   |  | 53. Signature of Registrar      |  | 54. Signature of Registrar           |  | 55. Signature of Registrar  |  |
| 56. Signature of Registrar       |  | 57. Signature of Registrar   |  | 58. Signature of Registrar      |  | 59. Signature of Registrar           |  | 60. Signature of Registrar  |  |
| 61. Signature of Registrar       |  | 62. Signature of Registrar   |  | 63. Signature of Registrar      |  | 64. Signature of Registrar           |  | 65. Signature of Registrar  |  |
| 66. Signature of Registrar       |  | 67. Signature of Registrar   |  | 68. Signature of Registrar      |  | 69. Signature of Registrar           |  | 70. Signature of Registrar  |  |
| 71. Signature of Registrar       |  | 72. Signature of Registrar   |  | 73. Signature of Registrar      |  | 74. Signature of Registrar           |  | 75. Signature of Registrar  |  |
| 76. Signature of Registrar       |  | 77. Signature of Registrar   |  | 78. Signature of Registrar      |  | 79. Signature of Registrar           |  | 80. Signature of Registrar  |  |
| 81. Signature of Registrar       |  | 82. Signature of Registrar   |  | 83. Signature of Registrar      |  | 84. Signature of Registrar           |  | 85. Signature of Registrar  |  |
| 86. Signature of Registrar       |  | 87. Signature of Registrar   |  | 88. Signature of Registrar      |  | 89. Signature of Registrar           |  | 90. Signature of Registrar  |  |
| 91. Signature of Registrar       |  | 92. Signature of Registrar   |  | 93. Signature of Registrar      |  | 94. Signature of Registrar           |  | 95. Signature of Registrar  |  |
| 96. Signature of Registrar       |  | 97. Signature of Registrar   |  | 98. Signature of Registrar      |  | 99. Signature of Registrar           |  | 100. Signature of Registrar |  |

13-300  
53 6743BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 53 6743  
Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

Length of stay in Baltimore

SEX

male white

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

Housewife

10a. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Lohr, James

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

NONE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

35 WILLIAMS DRIVE, Gwyn Park

B. DATE OF BIRTH

10-13-1902

9. AGE (In years  
last birthday)

30

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

PENNA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

14. MOTHER'S MAIDEN NAME

MARE E. ADAMS

17. INFORMANT

ADDRESS

HARRY BOOTH

- SAME

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) Anoxia due to post-operative  
disturbance of remaining  
Rt lobe & left lower lobe

3 days

(B)   
(C) Cardiac insufficiency due to  
anoxiaOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary XBC

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21/53, 19, to 7/23/53, 19, that I last saw the  
deceased alive on 7/23/53, 19, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24a. DATE

24c. NAME OF CEMETERY OR CREMATORY

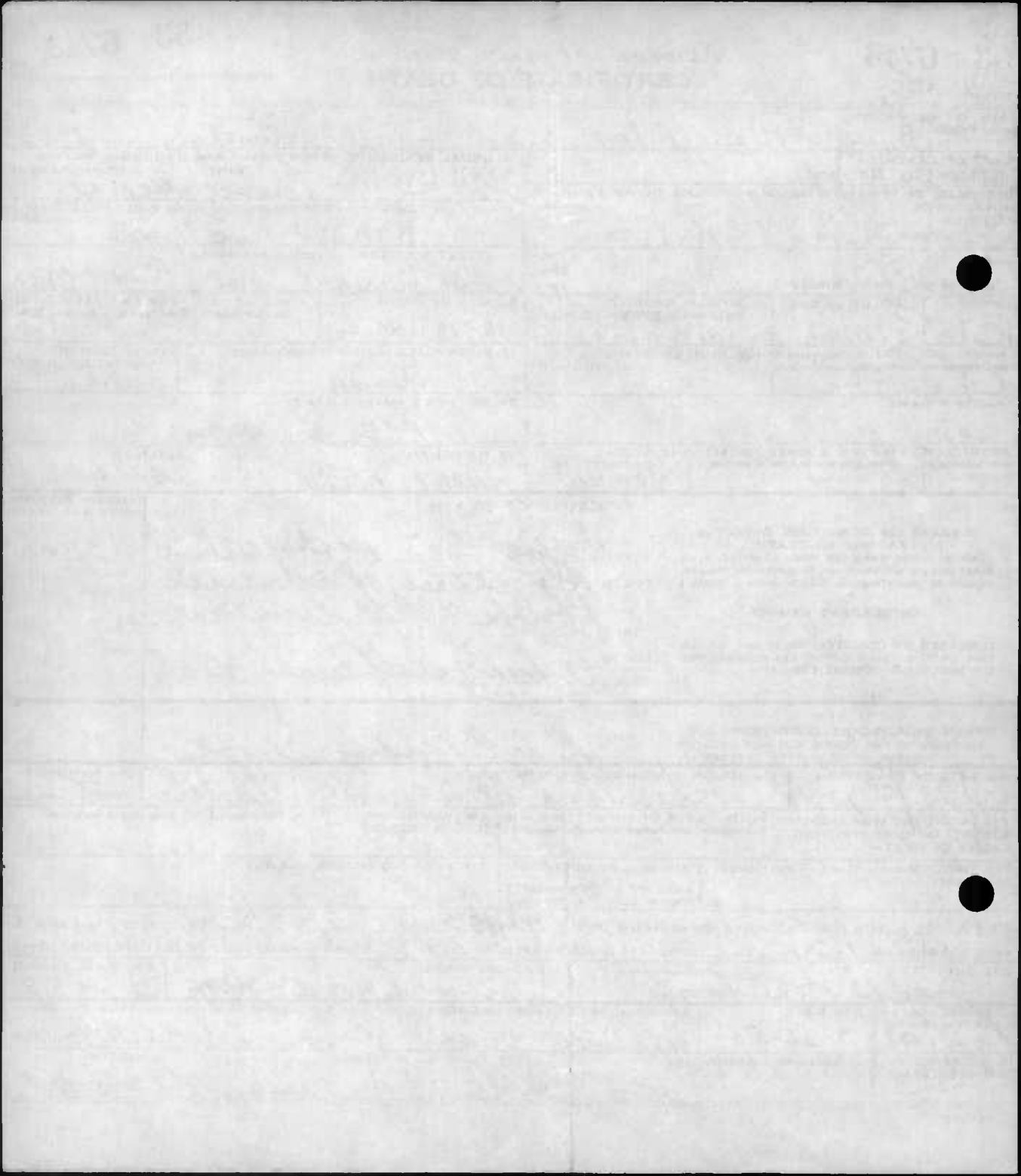
24d. LOCATION (City, town, or county) (State)

TE RECEIVED BY  
CITY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



⑤ K 245-  
53 6744

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6744

NAME OF DECEASED  
(Last, first, middle, or Print)

John A. Keseling

2. DATE  
OF  
DEATH

July 23/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
SPITAL OR  
TITUTION

707 Allendale St

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE  
B. COUNTY

16-08

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
707 Allendale St

Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

EX  
ale

6. COLOR OR RACE  
White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH  
Nov. 14, 1900

9. AGE (In years last birthday)  
52  
If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)  
E.X. Installer

10B. KIND OF BUSINESS OR INDUSTRY  
C.&P. Telephone Co.

11. BIRTHPLACE (State or foreign country)  
Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

ate John A. Keseling

14. MOTHER'S MAIDEN NAME

Mollie Keseling

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
212 05 0577

17. INFORMANT ADDRESS  
Mrs. Rachel Keseling, 707 Allendale

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

4 hrs.

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK WHILE AT ☐ WORK

22. I hereby certify that I attended the deceased from Jan, 1940, to July 23, 1953, that I last saw the deceased alive on July 23, 1953, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

7/27/53

Baltimore National

Baltimore, Md.

24E. RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

24E. RECEIVED BY  
CAL REGISTRAR

Huntington William

4101 Edmondson

4101 Edmondson

INSTITUTE OF HEALTH  
CERTIFICATE OF DEATH

|                             |  |                               |  |                                |  |                                |  |
|-----------------------------|--|-------------------------------|--|--------------------------------|--|--------------------------------|--|
| 1. Name of deceased         |  | 2. Sex                        |  | 3. Age                         |  | 4. Date of death               |  |
| 5. Place of death           |  | 6. Cause of death             |  | 7. Manner of death             |  | 8. Signature of physician      |  |
| 9. Signature of registrar   |  | 10. Signature of informant    |  | 11. Signature of witness       |  | 12. Signature of coroner       |  |
| 13. Signature of undertaker |  | 14. Signature of funeral home |  | 15. Signature of cemetery      |  | 16. Signature of church        |  |
| 17. Signature of school     |  | 18. Signature of employer     |  | 19. Signature of neighbor      |  | 20. Signature of family        |  |
| 21. Signature of community  |  | 22. Signature of state        |  | 23. Signature of federal       |  | 24. Signature of international |  |
| 25. Signature of world      |  | 26. Signature of universe     |  | 27. Signature of everything    |  | 28. Signature of nothing       |  |
| 29. Signature of all        |  | 30. Signature of none         |  | 31. Signature of some          |  | 32. Signature of many          |  |
| 33. Signature of few        |  | 34. Signature of much         |  | 35. Signature of little        |  | 36. Signature of great         |  |
| 37. Signature of small      |  | 38. Signature of big          |  | 39. Signature of tiny          |  | 40. Signature of huge          |  |
| 41. Signature of minute     |  | 42. Signature of colossal     |  | 43. Signature of infinitesimal |  | 44. Signature of infinite      |  |
| 45. Signature of eternal    |  | 46. Signature of temporal     |  | 47. Signature of immortal      |  | 48. Signature of mortal        |  |
| 49. Signature of immortal   |  | 50. Signature of mortal       |  | 51. Signature of immortal      |  | 52. Signature of mortal        |  |
| 53. Signature of immortal   |  | 54. Signature of mortal       |  | 55. Signature of immortal      |  | 56. Signature of mortal        |  |
| 57. Signature of immortal   |  | 58. Signature of mortal       |  | 59. Signature of immortal      |  | 60. Signature of mortal        |  |
| 61. Signature of immortal   |  | 62. Signature of mortal       |  | 63. Signature of immortal      |  | 64. Signature of mortal        |  |
| 65. Signature of immortal   |  | 66. Signature of mortal       |  | 67. Signature of immortal      |  | 68. Signature of mortal        |  |
| 69. Signature of immortal   |  | 70. Signature of mortal       |  | 71. Signature of immortal      |  | 72. Signature of mortal        |  |
| 73. Signature of immortal   |  | 74. Signature of mortal       |  | 75. Signature of immortal      |  | 76. Signature of mortal        |  |
| 77. Signature of immortal   |  | 78. Signature of mortal       |  | 79. Signature of immortal      |  | 80. Signature of mortal        |  |
| 81. Signature of immortal   |  | 82. Signature of mortal       |  | 83. Signature of immortal      |  | 84. Signature of mortal        |  |
| 85. Signature of immortal   |  | 86. Signature of mortal       |  | 87. Signature of immortal      |  | 88. Signature of mortal        |  |
| 89. Signature of immortal   |  | 90. Signature of mortal       |  | 91. Signature of immortal      |  | 92. Signature of mortal        |  |
| 93. Signature of immortal   |  | 94. Signature of mortal       |  | 95. Signature of immortal      |  | 96. Signature of mortal        |  |
| 97. Signature of immortal   |  | 98. Signature of mortal       |  | 99. Signature of immortal      |  | 100. Signature of mortal       |  |



2B-435-

53 6745

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

TH NO. 53 6745

NAME OF DECEASED  
(Last, first, middle, or Print)

Howard Worthington Baldwin

2. DATE  
OF  
DEATH

July 23/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR WINDSOR REST HOME  
INSTITUTION

3025 Windsor Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
Baltimore 20-07

D. STREET ADDRESS (If rural, give location)

79 S. Kossuth St

Length of stay in Baltimore 60 yrs.

Yrs.  
Mos.  
Days5. SEX  
Male  
6. COLOR OR RACE  
White  
7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Aug. 5/63

9. AGE (In years  
last birthday)

89

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)  
Retired Conductor10b. KIND OF BUSINESS OR  
INDUSTRY  
B. & O. R. R.

11. BIRTHPLACE (State or foreign country)

Avalon, Howard Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Thomas P. Baldwin

14. MOTHER'S MAIDEN NAME

-----Jones

13. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)  
No or unknown16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Roland Lee Baldwin, 143 S. Monastery

8. 422.1  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

5 yrs

8 yrs

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 0 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 18<sup>th</sup> 1948 to July 23, 1953 that I last saw the  
deceased alive on July 22<sup>nd</sup> 1953 and that death occurred at 1:30 Am., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

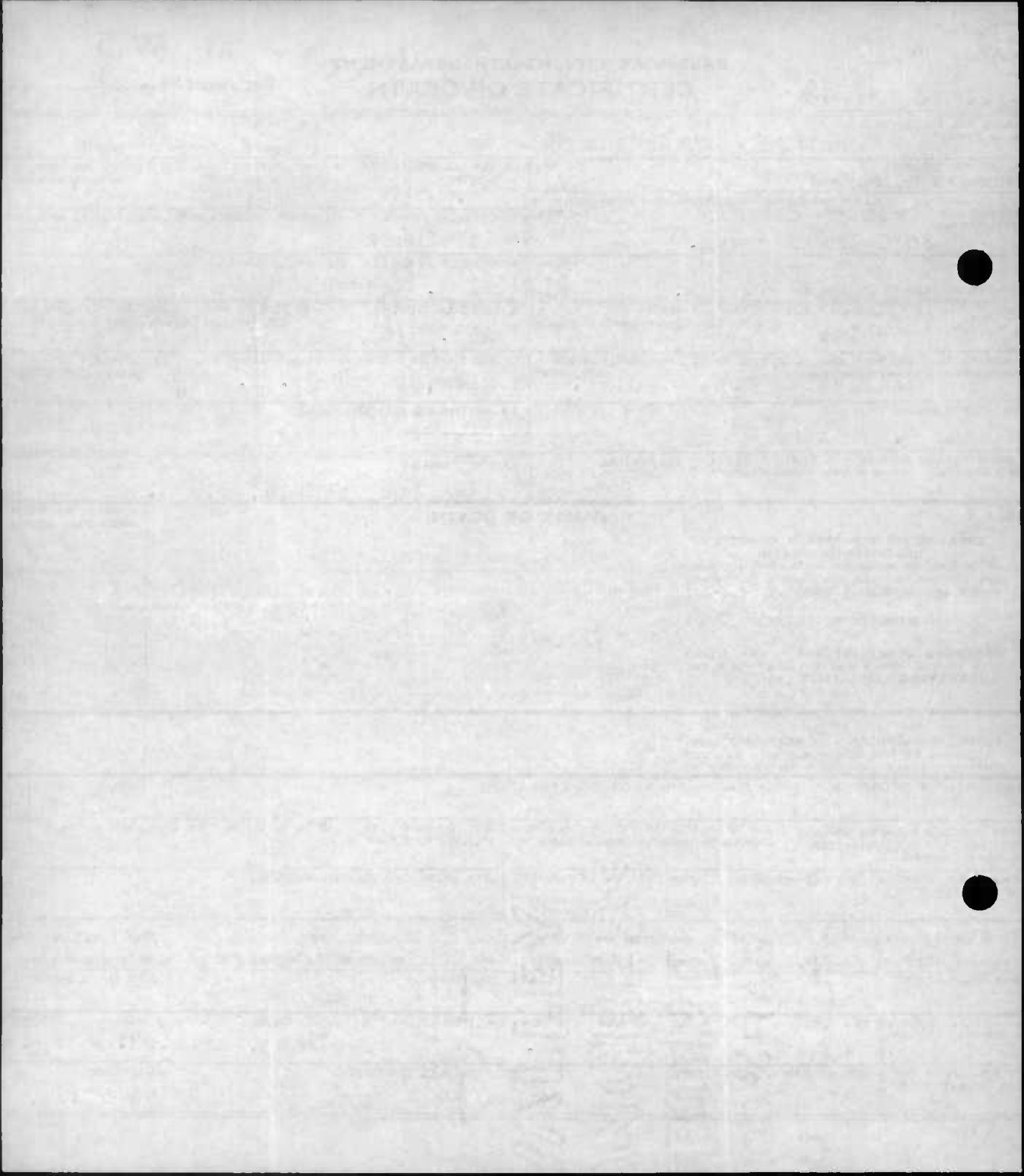
25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150



|  |  |
|--|--|
| <div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">T140</div> <div style="display: flex; justify-content: space-between;"> <span>53 6746</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>53 6746</span> </div> <div style="text-align: center; font-weight: bold; margin-bottom: 5px;">CERTIFICATE OF DEATH</div> <div style="text-align: right;">Registered No. _____</div>   |  |
| TH NO. _____   |  |
| NAME OF DECEASED (Please Print) <span style="float: right;">2. DATE OF DEATH</span><br><div style="display: flex; justify-content: space-between;"> <span>Georgia Margaret Teufel</span> <span>July 24/53</span> </div>  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>3605 Gelston Drive  |  |
| Length of stay in Baltimore <span style="float: right;">Yrs. Mos. Days</span><br>Life  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u> B. COUNTY _____   |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore <span style="float: right;">16-08</span>   |  |
| D. STREET ADDRESS (If rural, give location)<br>3605 Gelston Drive  |  |
| 5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow  |  |
| 8. DATE OF BIRTH <u>May 4, 1875</u> 9. AGE (In years last birthday) <u>78</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of one during most of working life, even if retired) <u>W.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? _____   |  |
| 13. FATHER'S NAME <u>o. Lehmuth</u> 14. MOTHER'S MAIDEN NAME <u>Mary Schaffer</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no or unknown</u> 16. SOCIAL SECURITY NO. _____   |  |
| 17. INFORMANT <u>Henry H. Teufel</u> ADDRESS <u>3605 Gelston Drive</u>   |  |
| 18. <u>470.1</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.         |  |
| (A) <u>Coronary insufficiency</u> DUE TO _____<br>(B) <u>Atherosclerosis</u> DUE TO _____<br>(C) _____   |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br><br><u>1 yr.</u>   |  |
| 19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____<br>21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____<br>21d. TIME (Month) (Day) (Year) (Hour) _____<br>21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK<br>21f. HOW DID INJURY OCCUR? _____ |  |
| 22. I hereby certify that I attended the deceased from <u>7/2/53</u> , 19 <u>53</u> , to <u>7/24/53</u> , that I last saw the deceased alive on <u>7/24/53</u> , and that death occurred at <u>11:00 a.m.</u> , from the causes and on the date stated above.  |  |
| 23a. SIGNATURE <u>William H. Teufel</u> 23b. ADDRESS <u>4031 W. 11th Ave</u> 23c. DATE SIGNED <u>7/24/53</u>   |  |
| 24a. DATE <u>July 27/53</u> 24b. NAME OF CEMETERY OR CREMATORY <u>Western</u> 24c. LOCATION (City, town, or county) <u>Balto. Md.</u>  |  |
| 25. FUNERAL DIRECTOR <u>Harry H. Teufel</u> ADDRESS <u>4101 Edmondson Ave.</u>   |  |

10-10-10

RECEIVED BY THE DIRECTOR

OFFICE OF THE DIRECTOR

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20090

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT

FROM: SAC, [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

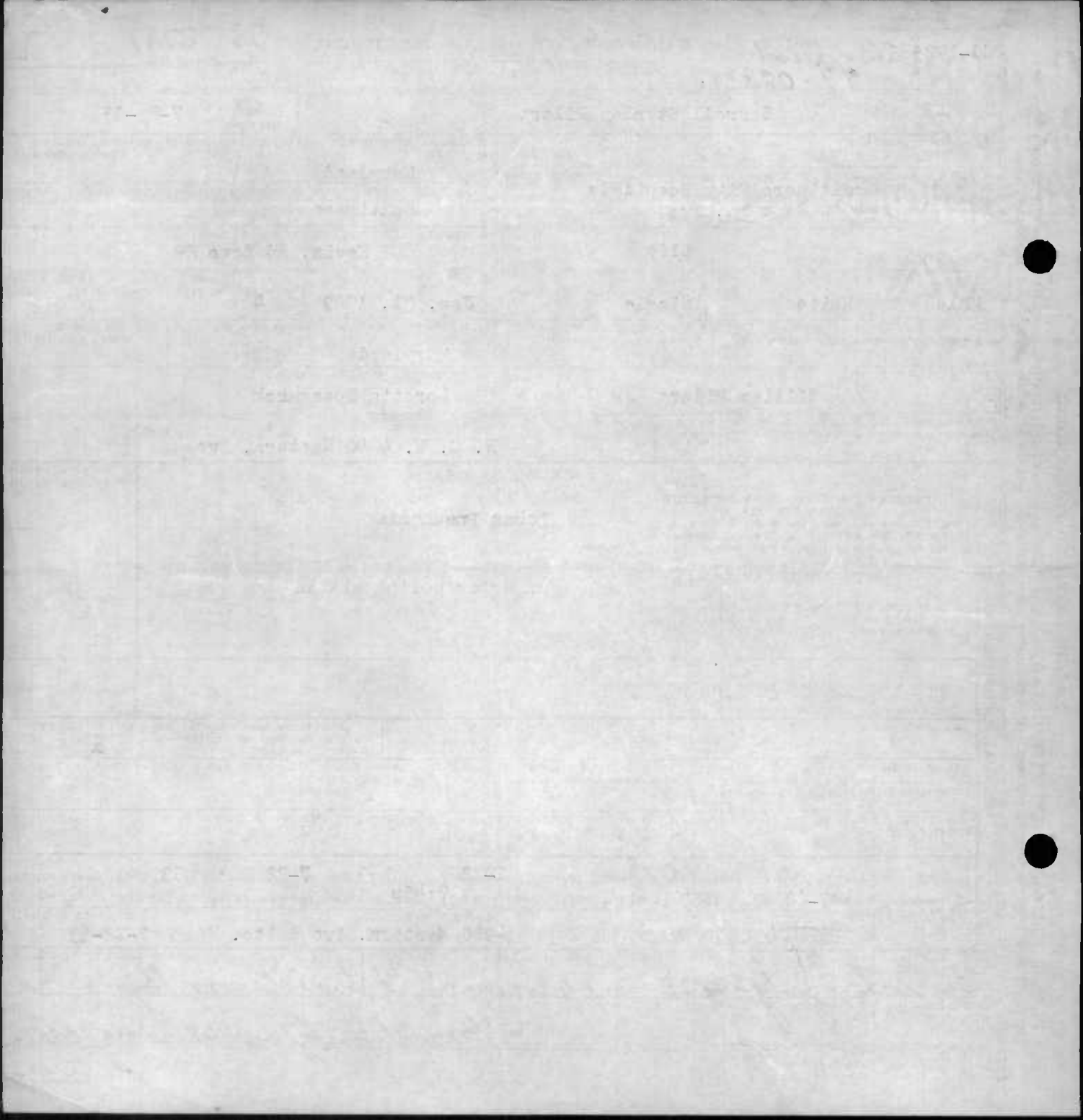
38. [illegible]

CCG-17258553

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6747  
Registered No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| BIRTH NO. <u>49-02231</u>   |                                  | 2. DATE OF DEATH <u>7-22-53</u>   |  |
| 1. NAME OF DECEASED (Type or Print) <u>Carroll Stanley Pilert</u>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                         |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | A. STATE <u>Maryland</u>  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern, Ave</u> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>28-04</u> |  |
| c. Length of stay in Baltimore <u>Life</u>  |                                  | D. STREET ADDRESS (If rural, give location)<br><u>802 Kevin, Rd Zone 29</u>                                   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Single</u>  | 8. DATE OF BIRTH<br><u>Jan. 31, 1949</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 9. AGE (in years last birthday)<br><u>4 1/2</u>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 13. FATHER'S NAME<br><u>William Pilert</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Loretta Rossmarck</u>  |  |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS<br><u>B. C. H. 4940 Eastern, Ave</u>  |  |

|   |  |  |  |
|---|--|--|--|
| 18. <u>080.0</u> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Lobar Pneumonia</u><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>✓</u>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Anterior poliomyelitis</u><br>( <u>bulbar</u> )<br>DUE TO  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |
| 19A. DATE OF OPERATION <u>7-22-53</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                               |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 22. I hereby certify that I attended the deceased from <u>7-22</u> , 1953, to <u>7-22</u> , 1953, that I last saw the deceased alive on <u>7-22</u> , 1953, and that death occurred at <u>7:45 p. m.</u> , from the causes and on the date stated above.  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 23A. SIGNATURE <u>Harry H. Witzke</u>   |  | 23B. ADDRESS <u>4940 Eastern, Ave Balto. Md</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE <u>July 25/53</u>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Ch. Woodlawn, Balto. Md.</u>  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                                 |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | 25. FUNERAL DIRECTOR ADDRESS<br><u>Harry H. Witzke, 4101 Edmondson Ave.</u>                            |  |





## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

53

6748

BIRTH NO.

53 6748

N.R.

1. NAME OF DECEASED  
(Type or Print)

Baby Boy STEPHEN

2. DATE  
OF  
DEATH

7/15/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

MD

B. COUNTY

CARROLL

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

WESTMINSTER

D. STREET ADDRESS (If rural, give location)

RFD #2

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7/15/13

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

3

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

WESTMINSTER, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

ARTHUR STEPHEN

14. MOTHER'S MAIDEN NAME

MABEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

FATHER

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Prematurely

INTERVAL BETWEEN  
ONSET AND DEATH

3 Hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....  
Do A

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Raymond J. Clemm

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

7/15/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL JUL 21 1953

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1953

Huntington Williams, Jr.

Huntington Williams, Jr.

NOT A MEDICAL EXAMINER'S CASE

Joseph A. Jachimczyk M.D.  
CHIEF ASST. MEDICAL EXAMINER

L-200  
53 6749BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6749  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOGUE, MRS ANNA VIRGINIA

2. DATE  
OF  
DEATH

7/23/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

11-02

b. FULL NAME OF (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

c. Length of stay in Baltimore

3

Mos.  
Days

d. STREET ADDRESS (If rural, give location)

1010 St. Paul St. apt. 2-3

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

Nov. 21, 1890

9. AGE (in years  
last birthday)

62

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Edward Madden

14. MOTHER'S MAIDEN NAME

Caroline Kolbenselley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Church Home &amp; Hospital

18. 446x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

10 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) arteriosclerotic kidney disease yrs.

(C) Generalized arteriosclerosis yrs.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Rheumatic Heart Disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 7/13, 1953, to 7/23, 1953, that I last saw the  
deceased alive on 7/23, 1953, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

David F. Carson M.D.

Church Home &amp; Hospital

7/23/53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Removal

24b. DATE

7/25/53

24c. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24d. LOCATION (City, town, or county)

Harrisburg, Pa.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tichner &amp; Sons

JUL 24 1953  
VS 150

Huntington Williams, M.D.

Baltimore, Md.

TO THE SECRETARY OF THE INTERIOR  
WASHINGTON, D. C.

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
DENVER, COLORADO

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a survey or a specific project. Key words that are faintly visible include "survey", "land", "area", "containing", "of", "the", "Bureau", "has", "determined", "that", "the", "area", "is", "suitable", "for", "the", "purpose", "of", "the", "project", "and", "it", "is", "recommended", "that", "the", "area", "be", "set", "aside", "as", "a", "reservation", "for", "the", "Bureau", "of", "Land", "Management".]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6750  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN

BURGESS

2. DATE  
OF  
DEATH

July 21, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF \_\_\_\_\_ not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE Baltimore City Morgue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

200 W. Preston St

C. Length of stay in Baltimore

5. SEX  
male6. COLOR OR RACE  
colored7. SINGLE [MARRIED] ☒  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

April 28

9. AGE (In years last birthday)

39

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Cont. Tricker

11. BIRTHPLACE (State or foreign country)

SC

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Peter Burgess

14. MOTHER'S MAIDEN NAME

Patree Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Burgess Brother W ADDRESS 1915 16 ST D.C.

18.

E974X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Hanging

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
laundry

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eutaw &amp; Biddle Streets

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

7-21-53

21E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

hanged self by rope

22. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ASSISTANT MEDICAL EXAMINER.....☐

23C. DATE SIGNED

7-22-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

July 25

24C. NAME OF CEMETERY OR CREMATORY

Lakewood Cemetery

24D. LOCATION (City, town, or county)

Shoarthville

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

A. Halstead

ADDRESS

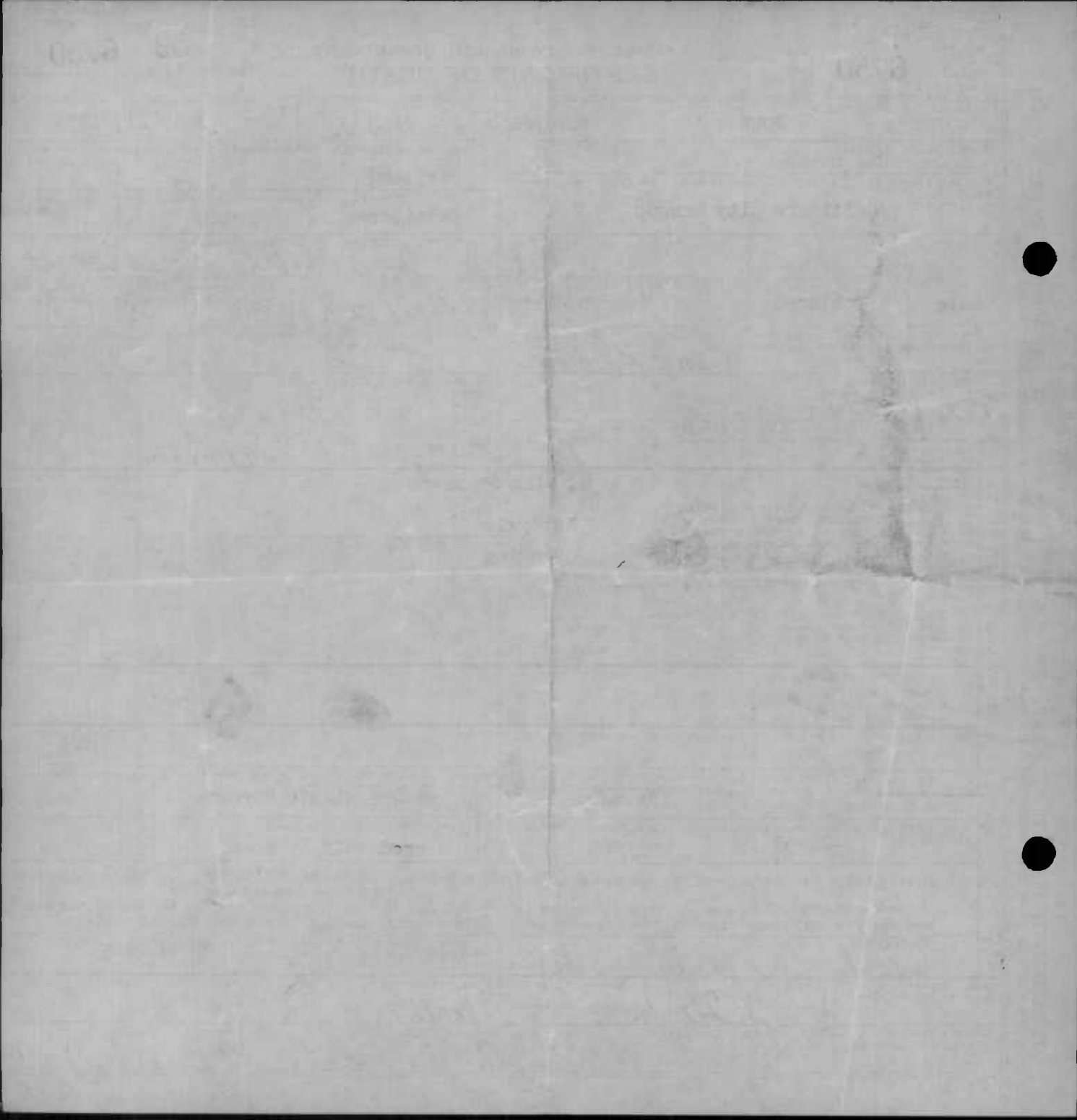
918-Druidhill

VS 151

N991X

97024

ave





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6751

53 6751

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AMBROSE A. CROSS, SR.

2. DATE  
OF  
DEATH

7-24-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MD.

B. COUNTY  
Howard

C. CITY OR TOWN

Ellicott City

D. STREET ADDRESS (If rural, give location)

72 Columbia Rd.

c. Length of stay in Baltimore

2 Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

6-23-88

9. AGE (In years  
last birthday)

65

10. Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Bus Driver

10B. KIND OF BUSINESS OR  
INDUSTRY

BTC

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Cross

14. MOTHER'S MAIDEN NAME

Georgianna Addison

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

215-09-6980

17. INFORMANT

Medical chart

ADDRESS

18.

422.1  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

myocardial failure

DUE TO

(B)

arteriosclerotic cardio-vascular disease

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

4 yrs

4+ yrs

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

possible strangulated left inguinal hernia 3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

22. I hereby certify that I attended the deceased from July 23, 1953 to July 24, 1953, that I last saw the deceased alive on July 24, 1953, and that death occurred at 6:19 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles F. Canale, Jr., M.D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

7-24-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-27-53

24C. NAME OF CEMETERY OR CREMATORY

Western Star

24D. LOCATION (City, town, or county)

Catonsville, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

F.C. Higinbotham, Ellicott City, Md.

# CERTIFICATE OF DEATH

100-10-115

12-11-1911

100-10-115

100-10-115

100-10-115

100-10-115

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13-320

53 6752

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6752  
Registered No.

|   |                                  |  |   |   |  |
|---|----------------------------------|--|---|---|--|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Madeline Bodejko</i>   |   | 2. DATE OF DEATH<br><i>July 24-1953</i>                                     |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Osler 3</i>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD</i><br>B. COUNTY <i>7-04</i> |   |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>                                     |   |   |  |
| C. Length of stay in Baltimore<br><i>41 Yrs.</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>918 N. Chester St</i>  |   |   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH<br><i>2 - 82</i>                           | 9. AGE (In years last birthday)<br><i>71</i>                                | 10. Under 1 Year Months: Days                |
| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><i>Tailor</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Suit Dressers</i>  | 11. BIRTH PLACE (State or foreign country)<br><i>Russia</i> |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i> |
| 13. FATHER'S NAME<br><i>?</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>?</i>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>215-05-7489</i>  |   | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>                      |  |
| 18. <i>204.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>(A) Agnogenic myeloid metaplasia</i><br>DUE TO           |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____ DUE TO<br>(C) _____   |                                  |  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |   |   |  |
| 19A. DATE OF OPERATION<br><i>7</i>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II |  |
| 20. AUTO-PSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>7-22</i> , 19 <i>53</i> , to <i>7-24</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7-24</i> , 19 <i>53</i> , and that death occurred at <i>730 A.M.</i> , from the causes and on the date stated above. |                                  |  |   |   |  |
| 23A. SIGNATURE<br><i>Henry N. Wagner Jr.</i>  |                                  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |   | 23C. DATE SIGNED<br><i>7/24/53</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 24B. DATE<br><i>BURIAL JULY 27 1953</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>HOLY TRINITY CEM</i>               |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>ELK RIDGE MD.</i>   |                                  |  |   |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 25 1953</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>  |   | 25. FUNERAL DIRECTOR ADDRESS<br><i>1800 E LOMBARD ST.</i>                   |  |

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B-320

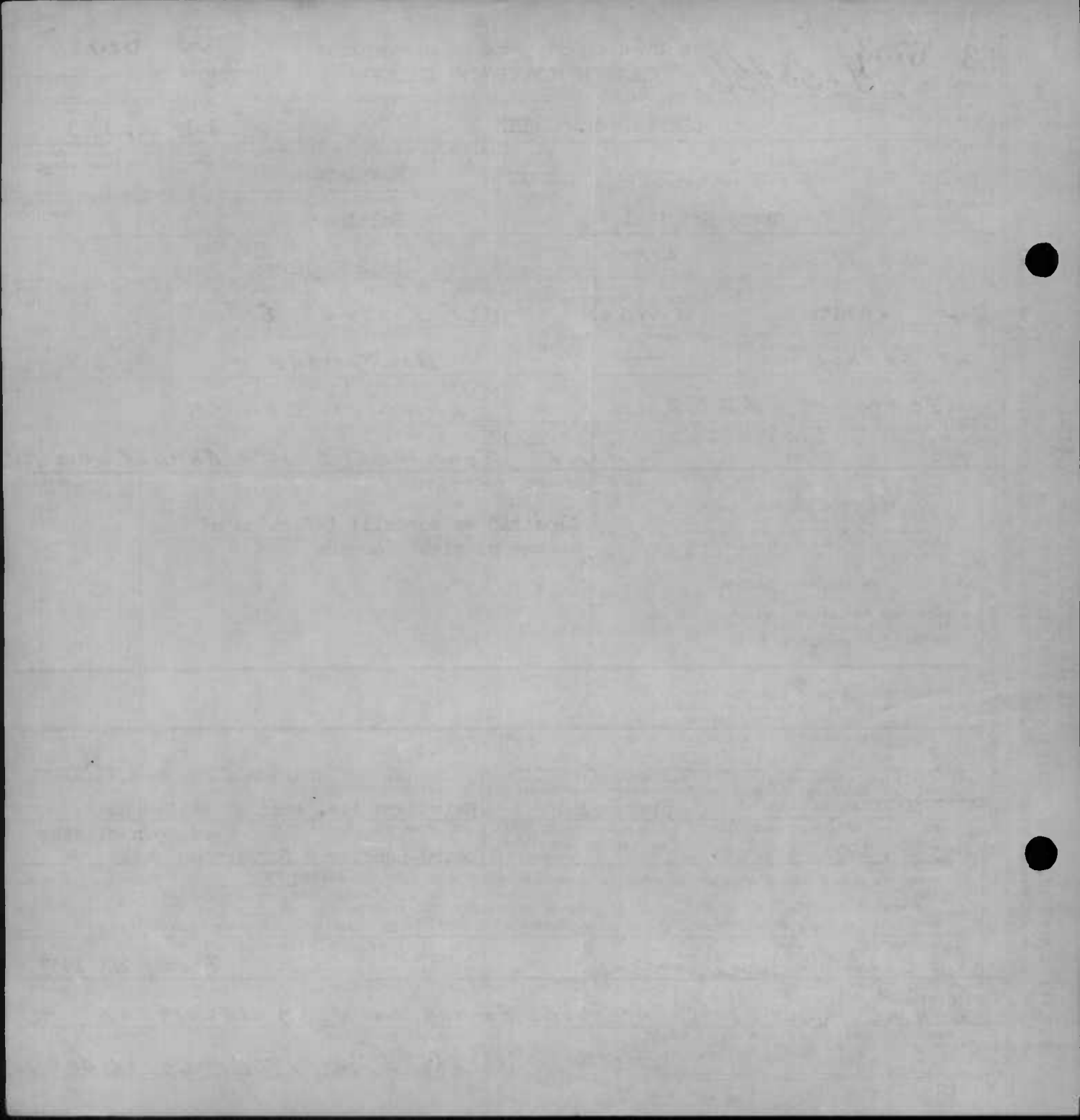
53 6753

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6753

Registered No.

|   |  |   |   |
|---|--|---|---|
| BIRTH NO. <b>53 6753</b>  |  | <b>58436</b>  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DENNIS R. BETZ</b>  |  | 2. DATE OF DEATH <b>July 24, 1953</b>   |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Mercy Hospital</b>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>27-38</b>               |   |
| c. Length of stay in Baltimore <b>LIFE</b> Yrs. Mos. Days   |  | D. STREET ADDRESS (If rural, give location)<br><b>1612 Ramblewood Road</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>                         | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b>  | 8. DATE OF BIRTH<br><b>OCT 5 1946</b>                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AT SCHOOL</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   | 9. AGE (In years last birthday)<br><b>6</b>                               |
| 13. FATHER'S NAME<br><b>JOHN M BETZ</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>JOHN M BETZ</b>   |  | ADDRESS<br><b>1612 RAMBLEWOOD RD.</b>   |   |
| 18. <b>E913.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Clostridium sordelli infection of wound of right forearm</b>   |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)  |  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |   |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>playground</b>              |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Belvedere Ave. east of Hillen Road</b>   |  | 21D. TIME (Month) (Day) (Year) (Hour)<br><b>July 20, 1953</b>   |   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR? <b>Slid down sliding board-punctured forearm on nail</b>   |   |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |   |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b>   |  | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....                            |   |
| 23C. DATE SIGNED<br><b>July 24, 1953</b>  |  |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 24B. DATE<br><b>JULY 27 1953</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>4430 BELAIR RD MD</b> |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>Montgomery Williams, Jr.</b> | 25. FUNERAL DIRECTOR<br><b>Chappel Bros</b>   | ADDRESS<br><b>1800 E LOMBARD ST.</b>                                      |





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

4-220  
53 6754

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6754

Registered No.

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH   |  |
| Mrs. Ruth Marie Hochhaus   |  | July 24, 1953  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>4700 Harford Road   |  | A. STATE<br>Maryland   |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore Kingsville |  |
| 5. SEX<br>female   |  | 6. DATE OF BIRTH<br>Feb. 17, 1888  |  |
| 6. COLOR OR RACE<br>white  |  | 7. AGE (In years last birthday)<br>65  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed   |  | 8. DATE OF BIRTH<br>Feb. 17, 1888  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home   |  | 9. AGE (In years last birthday)<br>65  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                                     |  |
| 13. FATHER'S NAME<br>Charles Spitznagle  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  | 14. MOTHER'S MAIDEN NAME<br>Kate ?   |  |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. E. Mardel Johnson, Kingsville Md   |  |

|  |  |  |
|--|--|--|
| 18. 331X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Broncho Pneumonia |  | INTERVAL BETWEEN ONSET AND DEATH<br>4 days |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) Hypertension<br>Cerebral Hemorrhage  |  | 8 years<br>4 months                        |

|  |  |  |  |
|--|--|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  |  |
| 19A. DATE OF OPERATION<br>None   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>None  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

|   |  |  |  |
|---|--|--|--|
| 22. I hereby certify that I attended the deceased from 7-20-1953, to 7-24-1953, that I last saw the deceased alive on 7-24-1953, and that death occurred at 1230 P. M., from the causes and on the date stated above. |  |  |  |
| 23A. SIGNATURE<br>L. Gordy  | 23B. ADDRESS<br>5106 Harford Road            | 23C. DATE SIGNED<br>7-24-53                                |  |
| 24A. BURIAL OR CREMATION<br>Burial  | 24B. DATE<br>July 27, 1953                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cem.   | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 25 1953   | REGISTRAR'S SIGNATURE<br>Huntington Williams | 25. FUNERAL DIRECTOR<br>Leonard J. Ruck, 5305 Harford Road |  |

Dr. Gordy

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

H-200

53 6755

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6755

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JAMES HOWARD HISS

2. DATE  
OF  
DEATH

24 July 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

South Baltimore General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-02

D. STREET ADDRESS (If rural, give location)

5104 Norwood Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11/14/1875

9. AGE (In years  
last birthday)

78

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesman

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

R. A.

George I Hiss

14. MOTHER'S MAIDEN NAME

Catherine Boyce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Frances Hiss - 5104 Norwood Ave.

18.

141X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) .....

DUE TO

Squamous cell carcinoma  
of tongue, right.

(B) .....

DUE TO

(C) .....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Hemorrhage from eroded vessel

INTERVAL BETWEEN  
ONSET AND DEATH

20. AUTOPSY?

YES ☐ NO ☒

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from January, 1952, to 24 July, 1953 that I last saw the deceased alive on 13 July, 1953, and that death occurred at 10:35 A., from the causes and on the date stated above.

23A. SIGNATURE

Arthur J. Swinski

M. D.

23B. ADDRESS

15 E. Biddle St.

23C. DATE SIGNED

24 July 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/27/53

24C. NAME OF CEMETERY OR CREMATORY

Green Mount Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

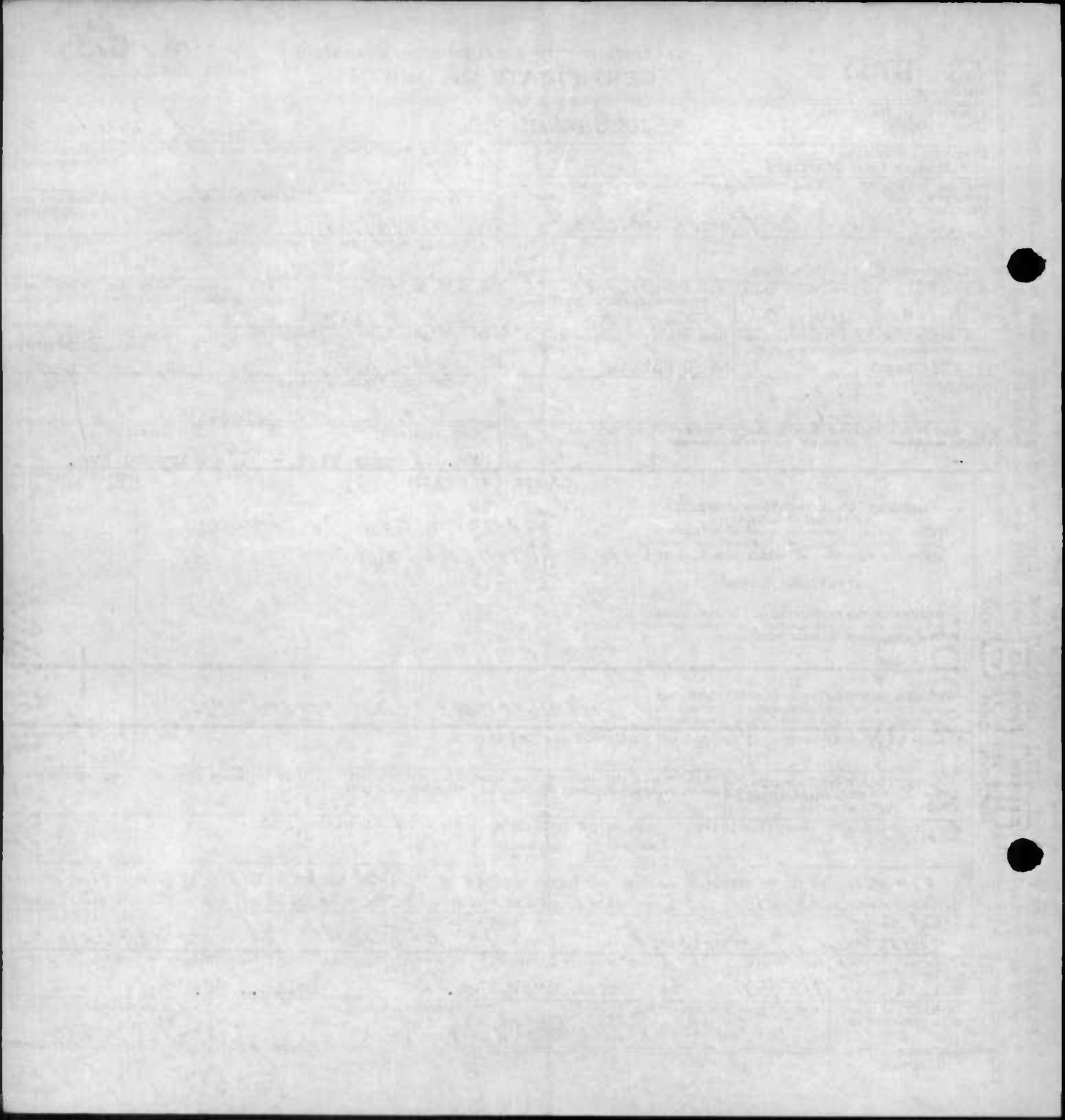
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tichner &amp; Sons

Balto 17, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| B-630<br>53 6756   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | Registered No. 53 6756   |  |
| BIRTH NO.  |  | N.R.  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | John Bridy  |  | 2. DATE OF DEATH<br>July 25, 1953  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | B. FULL NAME OF HOSPITAL OR INSTITUTION<br>JOHNS HOPKINS HOSPITAL   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>Pa<br>Atlas |  |
| 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Child   |  |
| 8. LENGTH OF STAY IN BALTIMORE   |  | 9. DATE OF BIRTH<br>12-27-49  |  | 10. AGE (In years last birthday)<br>3  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Pa.   |  | 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME<br>Albert D. Bridy   |  |
| 14. MOTHER'S MAIDEN NAME<br>Stella Procopio  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br>JOHNS HOPKINS HOSPITAL  |  | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Cerebrovascular thrombosis post-operative<br>Congenital heart disease, cyanotic<br>Pulmonary stenosis - I.A. defect |  | INTERVAL BETWEEN ONSET AND DEATH<br>? 2 hrs.   |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | 21. MEDICAL CERTIFICATION  |  |
| 19A. DATE OF OPERATION<br>7/25/53  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Congenital heart disease  |  | 19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                             |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7-21-1953 to 7-25-1953, that I last saw the deceased alive on 7-25-1953 and that death occurred at 1:00 P.M., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br>Arthur F. Nelson M.D.  |  | 23B. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  | 23C. DATE SIGNED<br>7/25/53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |  | 24B. DATE<br>July 25, 1953  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Higgins Funeral Home   |  |
| 24D. LOCATION (City, town, or county) (State)<br>Mount Carmel, Pennsylvania  |  | 24E. FUNERAL DIRECTOR<br>Carl B. Robertson Funeral Home   |  | 24F. ADDRESS<br>403-E-25th St, Baltimore-18 Md   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 26 1953 VS 150   |  | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  | 25. FUNERAL DIRECTOR<br>403-E-25th St, Baltimore-18 Md   |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 53 6757  
Registered No. \_\_\_\_\_

BIRTH NO. 53-16969

1. NAME OF DECEASED  
(Type or Print) BABY GIRL PRINCE

2. DATE OF DEATH 7-24-53

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE M.D. B. COUNTY BALTO

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
RELAY 53-00

Bon Secours Hospital

C. Length of stay in Baltimore 7 mo. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)  
4945 Tulip Ave

5. SEX FEMALE

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
SINGLE

8. DATE OF BIRTH 7-24-53

9. AGE (In years last birthday) 7  
H Under 1 Year Months Days  
H Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
NONE

10B. KIND OF BUSINESS OR INDUSTRY  
NONE

11. BIRTHPLACE (State or foreign country)  
M.D.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME  
John Prince

14. MOTHER'S MAIDEN NAME  
IRMA KORB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.  
NONE

17. INFORMANT ADDRESS  
John Prince, Relay, Md.

18. 761.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia due to  
placenta previa

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1953 to July 24, 1953, that I last saw the deceased alive on July 24, 1953, and that death occurred at 9 A. M., from the causes and on the date stated above.

23A. SIGNATURE  
J. Lloyd Johnson M. O.

23B. ADDRESS  
Catonsville Md

23C. DATE SIGNED  
7/24/53

24A. BURIAL, CREMATION, REMOVAL (Specify)  
BURIAL

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

24B. DATE  
7/25/53

24C. NAME OF CEMETERY OR CREMATORY  
PROSPECT HILL CEM.

24D. LOCATION (City, town, or county)  
Jowson, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE  
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

AUG 26 1953

Huntington Williams, M.D.

Easton Lane, Catonsville 28, Md.

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

1934

IN SENATE  
January 1, 1934

REPORT  
OF THE  
ATTORNEY GENERAL  
FOR THE YEAR  
1933

ALBANY:  
J.B. LIPPINCOTT COMPANY  
1934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward Travers

2. DATE  
OF  
DEATH

7/24/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Mercy Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3210 Abell Ave #18

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Sept 14, 1894

9. AGE (in years  
last birthday)

58

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Sheet Metal

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Travers

14. MOTHER'S MAIDEN NAME

Ann Vane

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 154X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) ...  
DUE TO

Postoperative hemorrhage

8 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...  
DUE TO

Cx rectum

3

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

July 24, 1953  
21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from July 19, 1953, to July 24, 1953, that I last saw the  
deceased alive on July 24, 1953, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert A. Moore Jr.

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

7/24/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/27/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John A. Moran

ADDRESS

3000 E. Baltimore St.

VS 150

69024

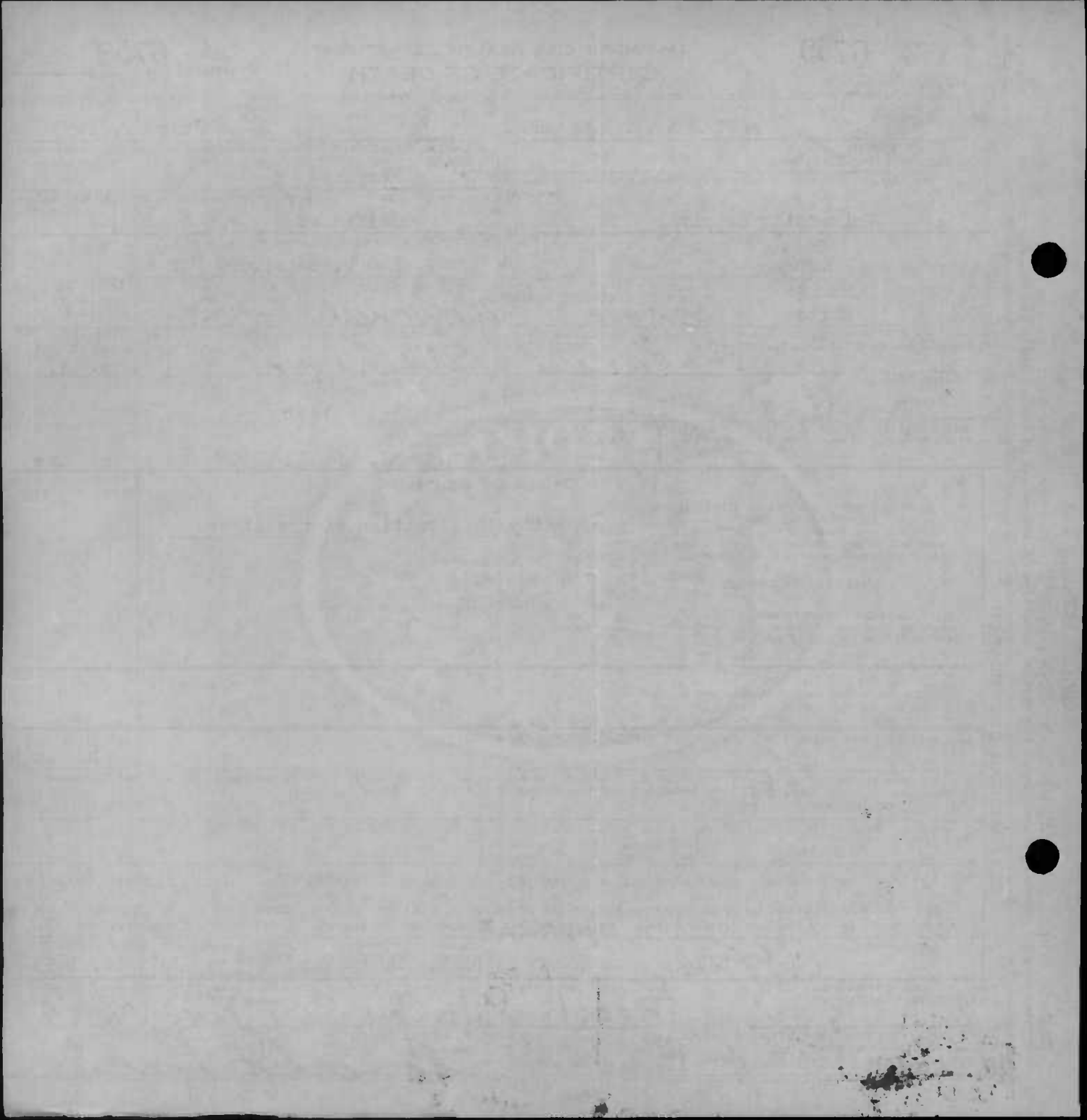
MINISTRE DU SÉRIEUX  
CERTIFICATE OF DEATH

|                              |  |                               |  |                               |  |
|------------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. Name of the deceased      |  | 2. Sex                        |  | 3. Age                        |  |
| 4. Date of birth             |  | 5. Date of death              |  | 6. Cause of death             |  |
| 7. Place of death            |  | 8. Signature of the physician |  | 9. Signature of the registrar |  |
| 10. Date of registration     |  | 11. Date of burial            |  | 12. Date of cremation         |  |
| 13. Date of inquest          |  | 14. Date of autopsy           |  | 15. Date of examination       |  |
| 16. Date of post-mortem      |  | 17. Date of necropsy          |  | 18. Date of toxicology        |  |
| 19. Date of histology        |  | 20. Date of pathology         |  | 21. Date of microbiology      |  |
| 22. Date of immunology       |  | 23. Date of serology          |  | 24. Date of virology          |  |
| 25. Date of bacteriology     |  | 26. Date of mycology          |  | 27. Date of parasitology      |  |
| 28. Date of entomology       |  | 29. Date of anthropology      |  | 30. Date of archaeology       |  |
| 31. Date of geology          |  | 32. Date of meteorology       |  | 33. Date of climatology       |  |
| 34. Date of oceanography     |  | 35. Date of hydrography       |  | 36. Date of limnology         |  |
| 37. Date of glaciology       |  | 38. Date of cryogenics        |  | 39. Date of cryobiology       |  |
| 40. Date of cryomedicine     |  | 41. Date of cryosurgery       |  | 42. Date of cryotherapy       |  |
| 43. Date of cryopreservation |  | 44. Date of cryoprotection    |  | 45. Date of cryopreservation  |  |
| 46. Date of cryoprotection   |  | 47. Date of cryopreservation  |  | 48. Date of cryoprotection    |  |
| 49. Date of cryopreservation |  | 50. Date of cryoprotection    |  | 51. Date of cryopreservation  |  |
| 52. Date of cryoprotection   |  | 53. Date of cryopreservation  |  | 54. Date of cryoprotection    |  |
| 55. Date of cryopreservation |  | 56. Date of cryoprotection    |  | 57. Date of cryopreservation  |  |
| 58. Date of cryoprotection   |  | 59. Date of cryopreservation  |  | 60. Date of cryoprotection    |  |
| 61. Date of cryopreservation |  | 62. Date of cryoprotection    |  | 63. Date of cryopreservation  |  |
| 64. Date of cryoprotection   |  | 65. Date of cryopreservation  |  | 66. Date of cryoprotection    |  |
| 67. Date of cryopreservation |  | 68. Date of cryoprotection    |  | 69. Date of cryopreservation  |  |
| 70. Date of cryoprotection   |  | 71. Date of cryopreservation  |  | 72. Date of cryoprotection    |  |
| 73. Date of cryopreservation |  | 74. Date of cryoprotection    |  | 75. Date of cryopreservation  |  |
| 76. Date of cryoprotection   |  | 77. Date of cryopreservation  |  | 78. Date of cryoprotection    |  |
| 79. Date of cryopreservation |  | 80. Date of cryoprotection    |  | 81. Date of cryopreservation  |  |
| 82. Date of cryoprotection   |  | 83. Date of cryopreservation  |  | 84. Date of cryoprotection    |  |
| 85. Date of cryopreservation |  | 86. Date of cryoprotection    |  | 87. Date of cryopreservation  |  |
| 88. Date of cryoprotection   |  | 89. Date of cryopreservation  |  | 90. Date of cryoprotection    |  |
| 91. Date of cryopreservation |  | 92. Date of cryoprotection    |  | 93. Date of cryopreservation  |  |
| 94. Date of cryoprotection   |  | 95. Date of cryopreservation  |  | 96. Date of cryoprotection    |  |
| 97. Date of cryopreservation |  | 98. Date of cryoprotection    |  | 99. Date of cryopreservation  |  |
| 100. Date of cryoprotection  |  | 101. Date of cryopreservation |  | 102. Date of cryoprotection   |  |

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6759  
Registered No.

|   |   |   |  |
|---|---|---|--|
| BIRTH NO.   |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |   | 2. DATE OF DEATH  |  |
| ANDERSON BYRNE BEALL  |   | July 22, 1953   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |   | A. STATE  |  |
| University Hospital   |   | Maryland  |  |
| C. Length of stay in Baltimore  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  |
| Yrs. Mos. Days  |   | Baltimore 18-01   |  |
| 5. SEX  |   | D. STREET ADDRESS (If rural, give location)   |  |
| Male  | 6. COLOR OR RACE                                | 866 W. Baltimore Street   |  |
| White   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH  |  |
|   | SINGLE  | UNKNOWN 70-?  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |   | 9. AGE (In years last birthday)   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)   |  |
| UNKNOWN   |   | UNKNOWN   |  |
| 13. FATHER'S NAME   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| John Beall  |   | U. S. A.  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                           |   | 14. MOTHER'S MAIDEN NAME  |  |
| (If yes, give war or dates of service)  |   | Elizabeth Berry   |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |
|   |   | Address   |  |
|   |   | Willis J. Beall 3208 Kueckert Ave   |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. 581.0<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| (A) Fatty infiltration of the liver  |  | DUE TO   |  |  |  |
| ANTECEDENT CAUSES  |  | (B)  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | DUE TO   |  |  |  |
| (C)  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?   |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |  |  |
| 23A. SIGNATURE   |  | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....  |  | 23C. DATE SIGNED   |  |
| R. S. Fisher   |  |  |  | July 22, 1953  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial   |  | July 28, 1953  |  | BEALLS Mills CEM SUTTON, W. VA.  |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR   |  |
| JUL 26 1953  |  | Huntington Williams, Jr.   |  | Leonard J. Ruck  |  |
| VS 151   |  |  |  |  |  |





1k  
rford  
at

R-526  
53 6760

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6760

Registered No.

BIRTH NO.

|   |                  |  |                                  |
|---|------------------|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)  |                  | 2. DATE OF DEATH   |                                  |
| Mr. George Ringrose   |                  | July 24, 1953  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |                                  |
| 4213 Ivanhoe Avenue   |                  | Baltimore 27-10  |                                  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                  | D. STREET ADDRESS (If rural, give location)  |                                  |
|   |                  | 4213 Ivanhoe Avenue  |                                  |
| 5. SEX  | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH                 |
| male  | white            | widowed  | March 3, 1875                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                     |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years, last birthday) |
| Retired   |                  |  | 78                               |
| 13. FATHER'S NAME   |                  | 11. BIRTHPLACE (State or foreign country)  |                                  |
| ?   |                  | Baltimore, Maryland  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                  | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
|   |                  | U.S.A.   |                                  |
| 16. SOCIAL SECURITY NO.   |                  | 14. MOTHER'S MAIDEN NAME   |                                  |
|   |                  | ?  |                                  |
| 17. INFORMANT   |                  | ADDRESS  |                                  |
|   |                  |  |                                  |

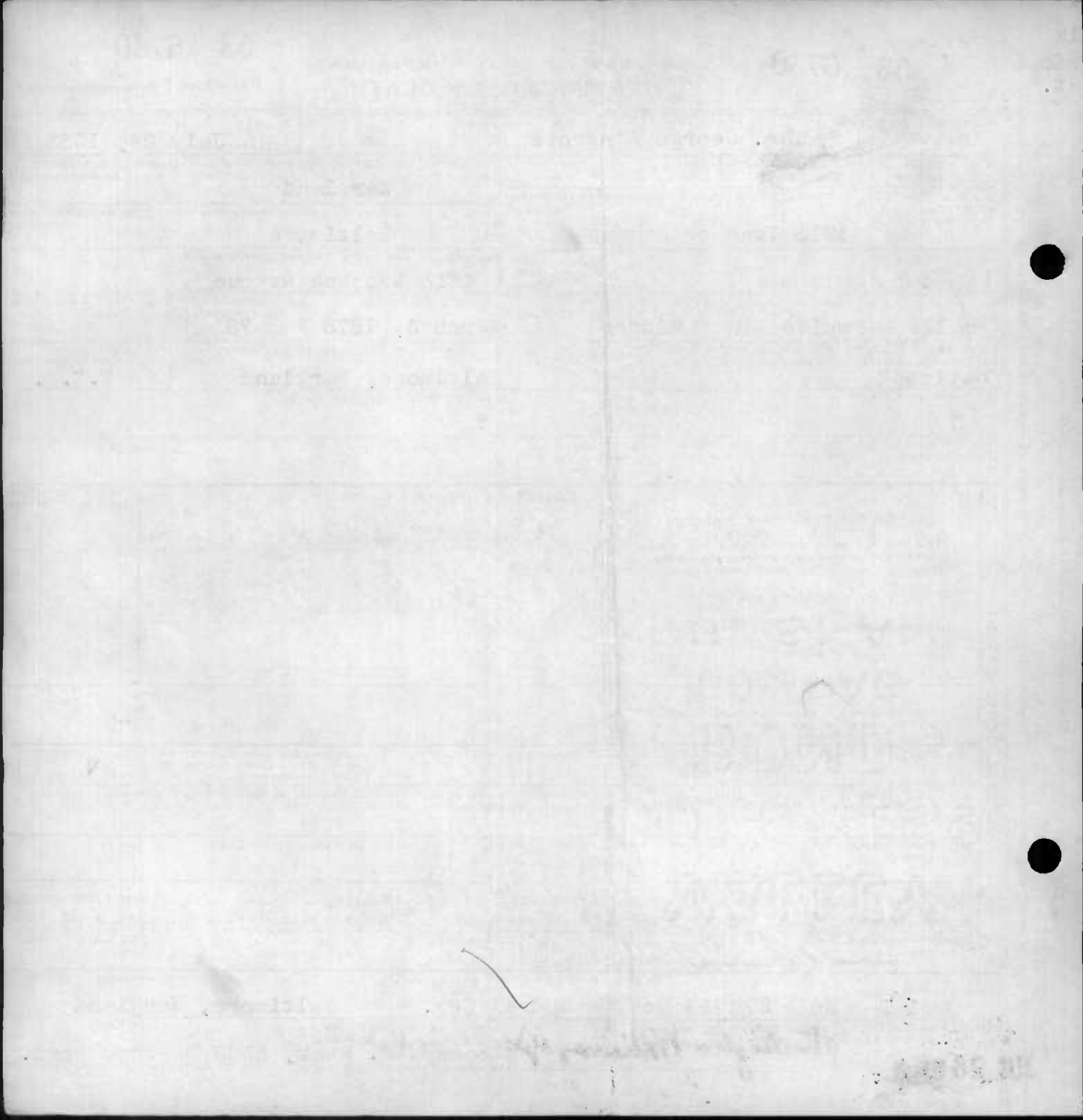
|   |                       |                                  |
|---|-----------------------|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH        | INTERVAL BETWEEN ONSET AND DEATH |
| 177X I  | Generalized Carcinoma |                                  |
| ANTECEDENT CAUSES   | Prostatic Carcinoma   |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                       |                                  |
|   |                       |                                  |

|  |  |  |   |
|--|--|--|---|
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |   |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from July 22, 1953, to July 24, 1953, that I last saw the deceased alive on 7/24, 1953, and that death occurred at 7:30 p. m., from the causes and on the date stated above. |  |  |   |
| 23A. SIGNATURE   | 23B. ADDRESS   | 23C. DATE SIGNED   |   |
| Frank T. Kavik   | 9005 Harford Rd  | 7/25/53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE  | 24C. NAME OF CEMETERY OR CREMATORY                                       | 24D. LOCATION (City, town, or county) (State)                         |
| Burial   | July 27 1953   | New Cathedral Cem.   | Baltimore, Maryland   |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |   |
|  |  | Huntington Williams, M.D.  |   |
|  |  | FUNERAL DIRECTOR   |   |
|  |  | Leonard J. Ruck, 5305 Harford Road.                                      |   |

JUL 26 1953

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 53 6761

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*ELIZABETH*  
**MARY A BANZ**

2. DATE  
OF  
DEATH

**7/25/53**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Mercy Hospital**

C. Length of stay in Baltimore

**Life**

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

**Baltimore**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**5719 Karon Ave.**

**26-01**

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Widow**

8. DATE OF BIRTH

**Sept. 11-1876**

9. AGE (In years last birthday)

**76**

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Bocklage**

14. MOTHER'S MAIDEN NAME

**—**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Mr. Charles L Banz - 3519 Juneway**

18. **420.1 I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Myocardial infarction**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

**Coronary Thrombosis**

(C)

INTERVAL BETWEEN ONSET AND DEATH

**} 24 hours**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/24**, 19**53**, to **7/25**, 19**53**, that I last saw the deceased alive on **7/25**, 19**53**, and that death occurred at **1:40** a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**7-28-53**

24C. NAME OF CEMETERY OR CREMATORY

**Sacred Heart**

24D. LOCATION (City, town, or county)

**Balto**

(State)

**Md**

DATE RECEIVED BY LOCAL REGISTRAR

**JUL 26 1953**

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Cuck 5305 Mayford**

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6762  
Registered No. \_\_\_\_\_

|  |                                  |  |   |  |   |
|--|----------------------------------|--|---|--|---|
| BIRTH NO. _____  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>TRAUPE Mrs Mary</b>  |   | 2. DATE OF DEATH<br><b>July 25, 1953</b>                                 |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto City</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> |   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Josephs Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore City</b>                                    |   |  |   |
| c. Length of stay in Baltimore   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5602 Trambre Road #14</b>  |   | <b>27-06</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>July 20-1884</b> | 9. AGE (In years last birthday)<br><b>69</b>                             | 10 Under 1 Year Months: Days Hours: Min.      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore - Md</b>       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Adam Dietrich</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Amelia</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS <b>5602</b><br><b>Mr. August Traupe - Tramore</b>  |   |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebro Accident</b><br>DUE TO<br><b>Auricular fibrillation</b><br><b>Generalized Arteriosclerosis</b><br><b>Myocardial infarction</b> |                                  | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |   |  |   |
| 19A. DATE OF OPERATION   |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>July 20, 1953</b> , to <b>July 25, 1953</b> , that I last saw the deceased alive on <b>July 25, 1953</b> and that death occurred at <b>3 A. m.</b> , from the causes and on the date stated above.   |                                  |  |   |  |   |
| 23A. SIGNATURE<br><b>Charles Fornop?</b>   |                                  | 23B. ADDRESS<br><b>St. Josephs Hospital</b>  |   | 23C. DATE SIGNED<br><b>7/25/1953</b>                                     |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>7-28-1953</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>London Park</b>                 |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>   |                                  | 24E. FUNERAL DIRECTOR<br><b>James Luck</b>   |   | 24F. ADDRESS<br><b>5305 Bayford.</b>                                     |   |





BIRTH NO.

1. NAME OF DECEASED (Type or Print) **EMMERMAN, EVA**

2. DATE OF DEATH **7/24/53**

3. PLACE OF DEATH: **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
 A. STATE **Calif** B. COUNTY **V-04**

5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
**Sunai**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Santa Monica**

7. STREET ADDRESS (If rural, give location)  
**129 Fraser Ave**

8. DATE OF BIRTH **052**

9. AGE (In years last birthday) **48**

10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**married**

11. BIRTH PLACE (State or foreign country)  
**Poland**

12. CITIZEN OF WHAT COUNTRY?  
**Poland**

13. FATHER'S NAME  
**Samuel**

14. MOTHER'S MAIDEN NAME  
**Getta**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
**no**

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Henry Emmerman - Son**

18. **193X** CAUSE OF DEATH  
**BRAIN TUMOR**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH  
**6 mo. +**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **7-20-53**

19B. MAJOR FINDINGS OF OPERATION  
**INOPERABLE BRAIN TUMOR**

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-15**, 19**53**, to **7-24**, 19**53**, that I last saw the deceased alive on **7-24**, 19**53**, and that death occurred at **4:50P** m., from the causes and on the date stated above.

23A. SIGNATURE  
**Norman L. Miller**

23B. ADDRESS  
**Smal Hosp OF BALTO. Inc.**

23C. DATE SIGNED  
**7-24-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Removal**

24B. DATE  
**7-24-53**

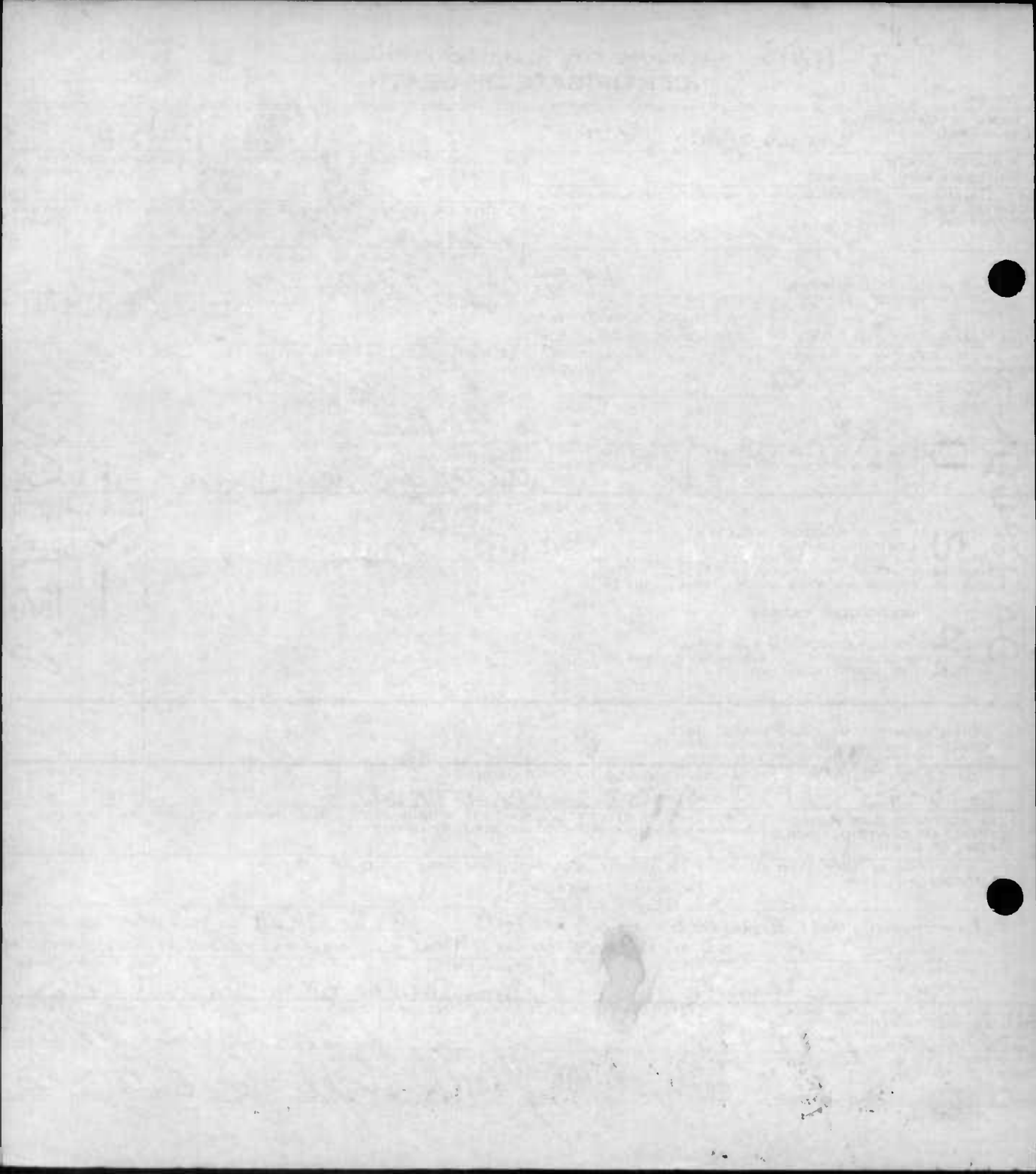
24C. NAME OF CEMETERY OR CREMATORY  
**Cleveland Ohio**

24D. LOCATION (City, town, or county) (State)  
**Cleveland Ohio**

25. FUNERAL DIRECTOR ADDRESS  
**Jack Kewin 2100 Guntow Pl**

DATE RECEIVED BY LOCAL REGISTRAR  
**26-53**

REGISTRAR'S SIGNATURE  
**Huntington**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6764  
Registered No.

BIRTH NO.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Oessie W. Waters</b>   |                               | 2. DATE OF DEATH <b>July 24, 1953</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Fla.</b><br>B. COUNTY <b>V-08</b> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>                                       |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Haines City</b>                                     |   |
| C. Length of stay in Baltimore <b>1 week</b>   |                               | D. STREET ADDRESS (If rural, give location)<br><b>Rt. #1 Box # 61</b>  |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   | 8. DATE OF BIRTH <b>10-2-02</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Barryman</b> |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self</b>   | 9. AGE (In years last birthday) <b>50</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Fla.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Wm Waters</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Mary Douglas</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)       |                               | 16. SOCIAL SECURITY NO.  |   |
|  |                               | 17. INFORMANT ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |

|  |  |  |
|--|--|--|
| 18. <b>442 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebro-vascular accident</b>                           |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min</b>                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertensive Cardiovascular-Renal disease</b>   |  | <b>2 yrs</b>   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>7-16</b> , 19 <b>53</b> , to <b>7-24</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-24</b> , 19 <b>53</b> , and that death occurred at <b>4:50 p.m.</b> , from the causes and on the date stated above. |  |  |
| 23A. SIGNATURE<br><b>Irving S. Rosenthal</b>   | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  | 23C. DATE SIGNED<br><b>24 July 53</b>                                    |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE<br><b>July 24/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Davenport Fla</b>               |
| 24D. LOCATION (City, town, or county) (State)<br><b>Davenport Fla</b>  | 25. FUNERAL DIRECTOR<br><b>Philips Norwig Sons</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE  | ADDRESS<br><b>2024 Calumet</b>   |

JUL 24 1953

10010

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

I hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_  
 19\_\_\_\_ at \_\_\_\_\_  
 the within named person died.  
 Name of deceased \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Cause of death \_\_\_\_\_  
 Signature of physician \_\_\_\_\_  
 Signature of registrar \_\_\_\_\_

I hereby certify that the above is a true and correct copy of the original certificate of death.  
 Signature of registrar \_\_\_\_\_  
 Date \_\_\_\_\_

I hereby certify that the above is a true and correct copy of the original certificate of death.  
 Signature of registrar \_\_\_\_\_  
 Date \_\_\_\_\_

AB-172593

BALTIMORE CITY HEALTH DEPARTMENT

53 6785  
Registered No.

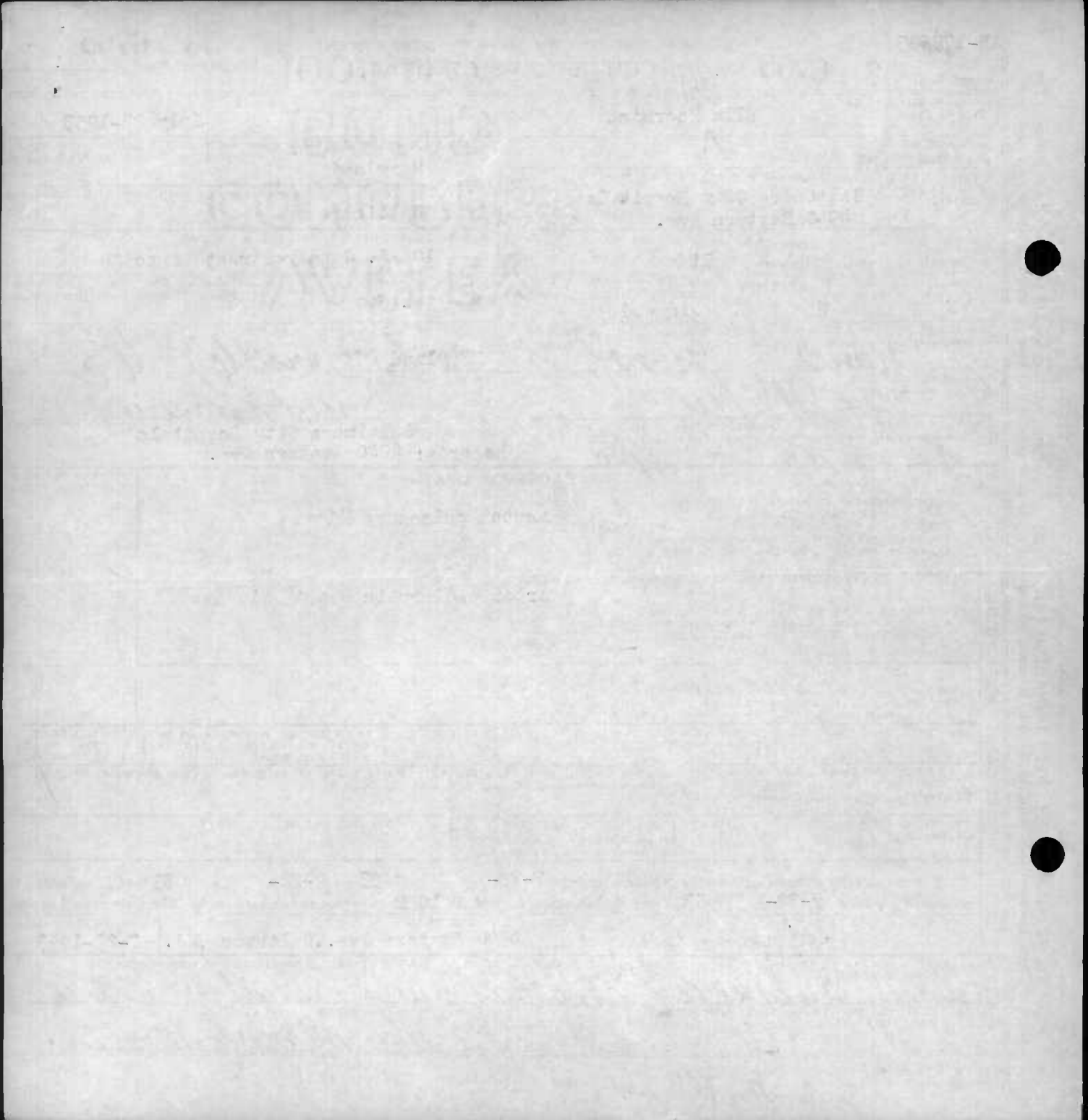
BIRTH NO. 53 6785

MAY  
CERTIFICATE OF DEATH

|  |                              |   |   |  |   |
|--|------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ella Koernick</b>  |                              |   | 2. DATE OF DEATH <b>July 22-1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b>        |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>                 |  |   |
| c. Length of stay in Baltimore <b>Life</b>   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>104 S. Janney Street zone 24</b>                                |  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>May 11-1879</b>  |  | 9. AGE (In years last birthday)<br><b>74</b>                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b> |                              |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland (Carroll Co)</b> |
| 13. FATHER'S NAME<br><b>Mr. Wiley</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>not known</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>                              |                              |   | 16. SOCIAL SECURITY NO.<br><b>No</b>  |  |   |
| 17. INFORMED BY<br><b>Baltimore City Hospitals</b>   |                              |   | 18. RECORDS: <b>4940 Eastern Ave.</b>   |  |   |

|   |   |  |   |
|---|---|--|---|
| 18. <b>470.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Pulmonary Edema</b>                              |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerotic Heart Disease</b>   |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |   |
| 19A. DATE OF OPERATION<br><b>7-22-53</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7-22-</b> , 19 <b>53</b> , to <b>7-22-</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7-22-</b> , 19 <b>53</b> , and that death occurred at <b>10 P.m.</b> , from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><b>H. John Doe</b>  |   | 23B. ADDRESS<br><b>4940 Eastern Ave., Baltimore, Md.</b>                 | 23C. DATE SIGNED<br><b>7-23-1953</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>July 28/53</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore City Cemetery</b>     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>              |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>Stewart-Morgan-Balto.</b>                     |   |

JUL 26 1953





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONA. STATE  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 762.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 24 July 1952, to 25 July 1952, that I last saw the  
deceased alive on 25 July, 1952, and that death occurred at 10<sup>45</sup> pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

James James O'Brien

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-520

53 6767

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

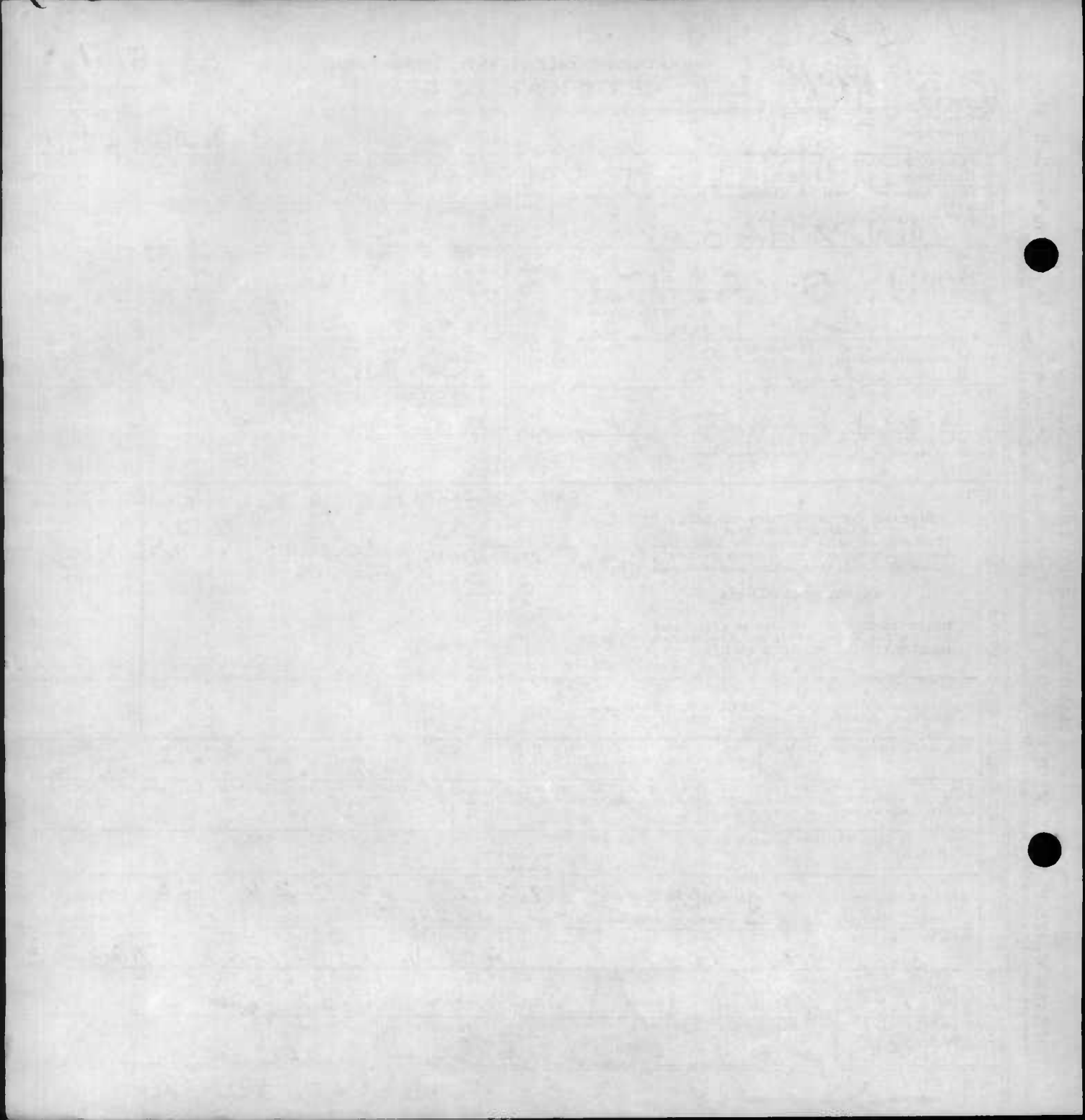
53 6767  
Registered No.

|  |                              |   |   |   |   |
|--|------------------------------|---|---|---|---|
| BIRTH NO.  |                              | 1. NAME OF DECEASED<br>(Type or Print) <u>Lula J Dennis</u>   |   | 2. DATE OF DEATH <u>July 24th/53</u>      |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>1118 Etting St</u>                                      |                              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>Balto.</u> |   |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>1118 Etting St</u>  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto.</u> <u>17-02</u>                                 |   |   |   |
| C. Length of stay in Baltimore <u>50 year</u>  |                              | D. STREET ADDRESS (If rural, give location) <u>1118 Etting St</u>   |   |   |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>Col.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>  | 8. DATE OF BIRTH <u>77</u>                                  | 9. AGE (In years last birthday) <u>77</u> | 10. Under 1 Year Months: Days             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic.</u> |                              | 10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>  | 11. BIRTHPLACE (State or foreign country) <u>Boydton VA</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13. FATHER'S NAME <u>Alfred Smith</u>  |                              | 14. MOTHER'S MAIDEN NAME <u>Mollie Baskerville</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>                                   |                              | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT <u>Minerva</u>              |   |

|   |                                      |                                  |
|---|--------------------------------------|----------------------------------|
| 18. <u>422.1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>arterio sclerotic cardiac vascular Disease</u> | CAUSE OF DEATH <u>Blackridge Va.</u> | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (A) DUE TO                           |                                  |
|   | (B) DUE TO                           |                                  |
|   | (C) DUE TO                           |                                  |

|  |  |
|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 21F. HOW DID INJURY OCCUR?   |  |

|  |  |
|--|--|
| 22. I hereby certify that I attended the deceased from <u>7.20.</u> , 19 <u>53</u> , to <u>7.24</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7.23</u> , 19 <u>53</u> , and that death occurred at <u>2:25</u> a.m., from the causes and on the date stated above. |  |
| 22A. SIGNATURE <u>James M. Fair</u>  | 22B. ADDRESS <u>400 N. Carrollton</u>                          |
| 22C. DATE SIGNED <u>7.24.53</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 24B. DATE <u>7/26/53</u>                                       |
| 24C. NAME OF CEMETERY OR CREMATORY <u>MT Auburn</u>  | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> |
| DATE RECEIVED BY LOCAL REGISTRAR <u>7/26/53</u>  | REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>         |
| 25. FUNERAL DIRECTOR <u>Chas O Wilson</u>  |  |
| ADDRESS <u>1000 Parantley Av.</u>  |  |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6768  
Registered No.

BIRTH NO.

|   |                              |   |                              |
|---|------------------------------|---|------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JACK SCHWARTZ</b>   |                              | 2. DATE OF DEATH <b>7/25/53</b>   |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>-</b> |                              |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>University Hoop.</b> |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                |                              |
| c. Length of stay in Baltimore  |                              | D. STREET ADDRESS (If rural, give location)<br><b>3919 Greenmount Ave. 9-01</b>   |                              |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>   | 8. DATE OF BIRTH<br><b>1</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Insurance</b>  |                              |
| 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?  |                              |
| 13. FATHER'S NAME<br><b>Caron</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary</b>   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                              | 16. SOCIAL SECURITY NO.   |                              |
| 17. INFORMANT<br><b>Caroline Schwartz</b>   |                              | ADDRESS<br><b>same</b>  |                              |

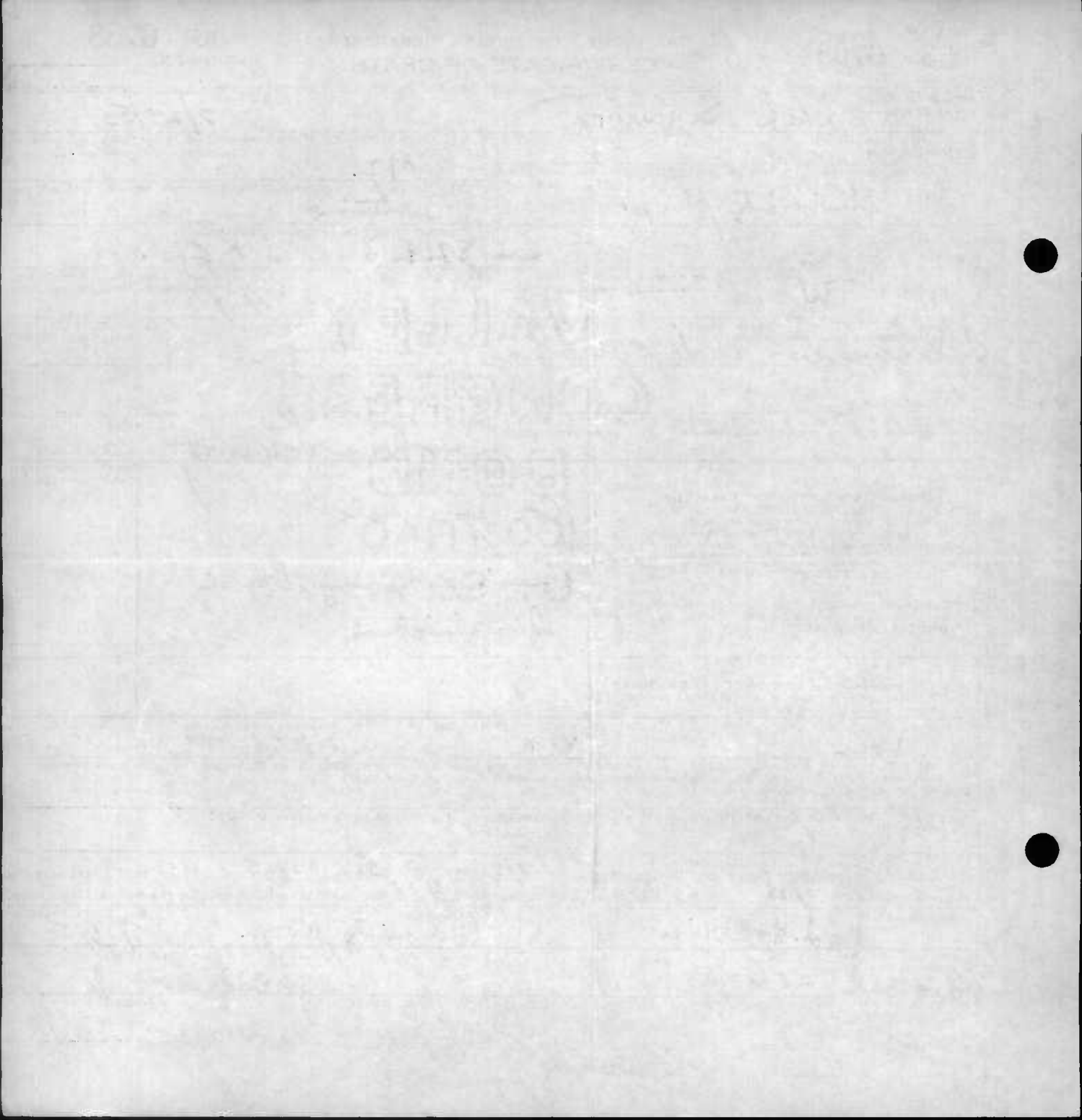
|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>576 X 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cor pulmonale</b> | CAUSE OF DEATH<br>(A) <b>Cor pulmonale</b><br>DUE TO                     | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>chronic pulmonary fibrosis</b>   | (B) <b>chronic pulmonary fibrosis</b><br>DUE TO<br><b>bronchiectasis</b> |                                  |
| (C)   |  |                                  |

|  |  |
|--|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
|--|--|

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><b>home</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

|   |   |                                    |
|---|---|------------------------------------|
| 22. I hereby certify that I attended the deceased from <b>7/5</b> , 19 <b>53</b> , to <b>7/25</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/25</b> , 19 <b>53</b> , and that death occurred at <b>4 P</b> m., from the causes and on the date stated above. |   |                                    |
| 23A. SIGNATURE<br><b>A. H. Weiner</b>   | 23B. ADDRESS<br><b>University Hoop.</b> | 23C. DATE SIGNED<br><b>7/26/53</b> |

|   |  |   |   |
|---|--|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24B. DATE<br><b>7-26-53</b>                              | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Huntington Williams, Md.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Rochester N. Y.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 26 1953</b>      | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Md.</b> | 25. FUNERAL DIRECTOR<br><b>Jack Lewis</b>                             | ADDRESS<br><b>3100 Canton Pl</b>  |
| <b>45073</b>  |  |   |   |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6769  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rudolph A. Novak

2. DATE  
OF  
DEATH

July 24, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

2712 Orleans St

4. USUAL RESIDENCE (Where deceased lived, Institution: residence  
A. STATE B. COUNTY before admission)

A. STATE

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt

D. STREET ADDRESS (If rural, give location)

2712 Orleans St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 25, 1890

9. AGE (In years  
last birthday)

62

10. Under 1 Year  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Patrolman Retired Balto Police Dept

10B. KIND OF BUSINESS OR  
INDUSTRY

Balto Police Dept

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Novak

14. MOTHER'S MAIDEN NAME

Catherine Osuals

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL  
SECURITY NO.

213-28-5086

17. INFORMANT

Barclay Novak 2712 Orleans St

ADDRESS

18.

153X 1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

Congestive Heart Failure

Generalized Carcinomatosis

Carcinoma of Descending Colon

INTERVAL BETWEEN  
ONSET AND DEATH

3 weeks

6 months

2 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 1951, to July 24, 1953 that I last saw the  
deceased alive on July 22, 1953, and that death occurred at 10:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Isaac Rosen

M. D.

23B. ADDRESS

2413 E. Monument St 7/22/53

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 27, 1953

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

A. A. B. O.

(State)

Ind

DATE RECEIVED BY REGISTRAR'S SIGNATURE  
LOCAL REGISTRAR

JUL 26 1953

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

A. Howard Evans 1400 S. Charles St

ADDRESS

8072

15

7

CERTIFICATE AMEND 7/29/53 ES

53 6770

Registered No.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

BIRTH NO.

171105 AJ H

1. NAME OF DECEASED  
(Type or Print)

Carl Lee Mach

2. DATE  
OF  
DEATH

7-24-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

4940 Eastern Ave City 24

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

717 S. Durham St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 22 51

9. AGE (In years last birthday)

2

11 Under 1 Year  
Months Days12 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M aryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

L eon J ohn Mach

14. MOTHER'S MAIDEN NAME

Evelyn Vogel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

(Records) 4940 Eastern Ave

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Central Nervous System Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tubercular meningitis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-10, 1953, to 7-24, 1953, that I last saw the deceased alive on 7-24, 1953 and that death occurred at 11:30 pm from the causes and on the date stated above.

23A. SIGNATURE

Huntington Williams, M.D.

23B. ADDRESS

4940 Eastern Ave

23C. DATE SIGNED

7-25 53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 27, 1953

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City and county)

Baltimore,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVENUE

JUL 26 1953

VS 150

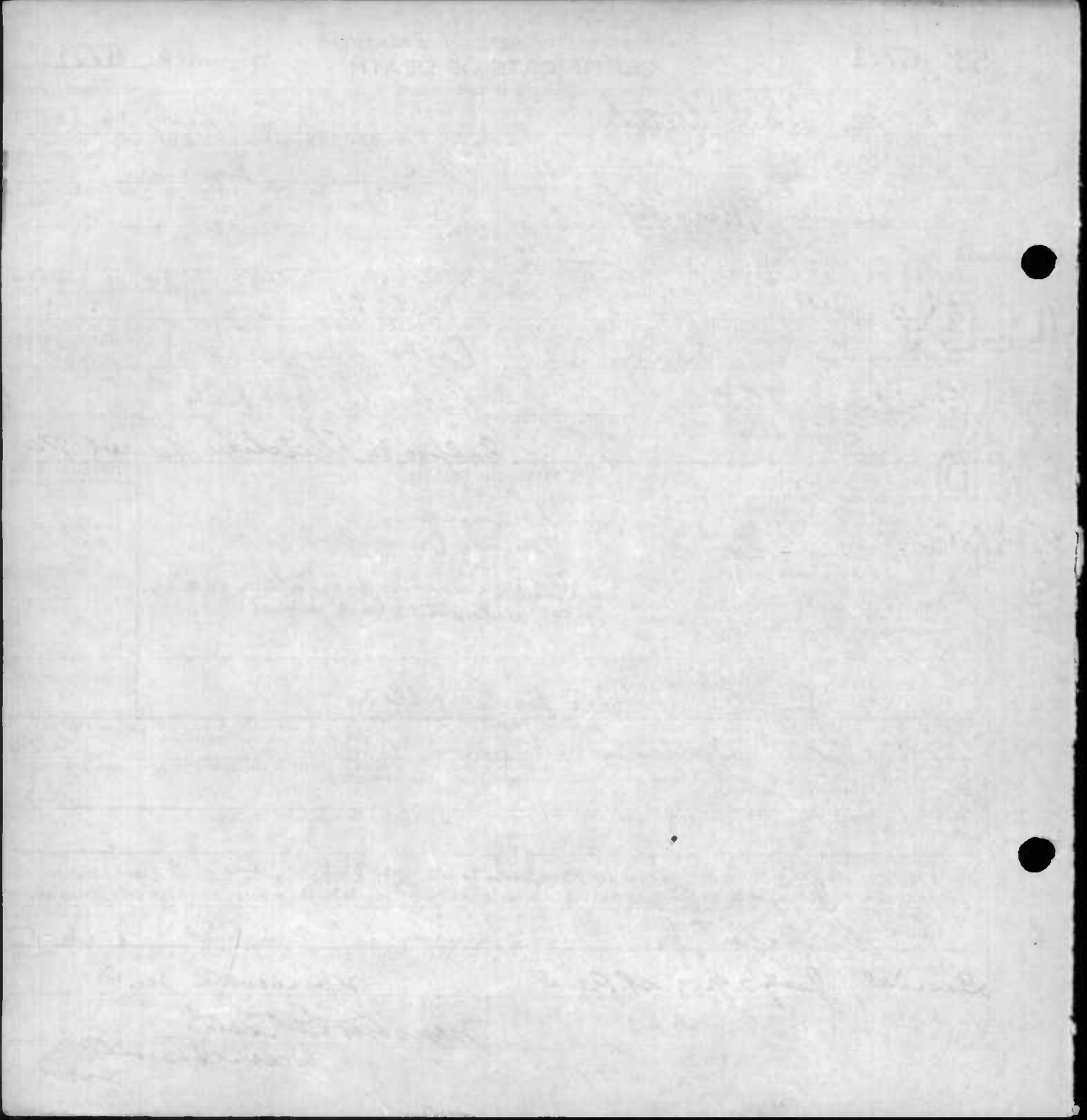
Huntington Williams, M.D. Charles S. Sadowski

Dr. Hardie, Pediatric Director, BCMD  
called Baltimore City Hospitals re diagnosis  
also record in TBC Bureau, BCMD

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

Registered No. **53 6771**

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. Frank Fletcher</b>   |                              | 2. DATE OF DEATH<br><b>July 26, 1953</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Harford</b> |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>38 University Hospital</b>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Street 62-00</b>                                   |  |
| c. Length of stay in Baltimore <b>15</b> Yrs. Mos. Days  |                              | d. STREET ADDRESS (If rural, give location)   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>   | 8. DATE OF BIRTH<br><b>3-18-90</b>           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b>  | 9. AGE (In years last birthday)<br><b>63</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Rocks, Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Nicholas Fletcher</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca M. Ray</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>  |                              | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Ralph H. Fletcher</b>  |                              | ADDRESS<br><b>Laurel Pk</b>   |  |
| 18. <b>177X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Uremia</b><br>DUE TO <b>Urinary Tract obst.</b><br>ANTECEDENT CAUSES<br><b>Carcinoma prostatica metast.</b><br>DUE TO <b>metastases &amp; spread.</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Resistant to blues</b> |                              |   | INTERVAL BETWEEN ONSET AND DEATH             |
| 19a. DATE OF OPERATION<br><b>7-13-53</b>   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma - Obstr. bowel</b>   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                              | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                              | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 26, 1953</b> to <b>July 26, 1953</b> , that I last saw the deceased alive on <b>July 26, 1953</b> , and that death occurred at <b>4:55</b> m., from the causes and on the date stated above.  |                              |   |  |
| 23a. SIGNATURE<br><b>F. E. H. H. H. H.</b>   |                              | 23b. ADDRESS<br><b>University Hospital</b>  |  |
| 23c. DATE SIGNED<br><b>7-26-53</b>   |                              | 23d. LOCATION (City, town, or county) (State)<br><b>Harford Md</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 24b. DATE<br><b>July 29-53</b>  |  |
| 24c. NAME OF CEMETERY OR CREMATORY<br><b>St Paul</b>   |                              | 24d. LOCATION (City, town, or county) (State)<br><b>Harford Md</b>  |  |
| 25. FUNERAL DIRECTOR<br><b>Huntington H. H. H.</b>   |                              | ADDRESS<br><b>Marshall Street</b>   |  |
| 26. LOCAL REGISTRAR<br><b>Jul 27 1953</b>  |                              | 27. REGISTRAR'S SIGNATURE<br><b>Huntington H. H. H.</b>   |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-624

53 6772

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6772

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM CLINTON TROGLER

2. DATE  
OF  
DEATH

JULY 25, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2825 FREDERICK AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 20-06

D. STREET ADDRESS (If rural, give location)

2825 FREDERICK AVE.

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

FEBRUARY 9, 1901

9. AGE (In years last birthday)

72

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LIVE STOCK HANDLER

10B. KIND OF BUSINESS OR INDUSTRY

Stock yards.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

THOMAS TROGLER

14. MOTHER'S MAIDEN NAME

DERRENBERGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL SECURITY NO.

214-03-6412

17. INFORMANT

WILLIAM P. TROGLER 2825 FREDERICK AVE

18. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Coronary Sclerosis  
Hypertension

years  
years

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949 to July 25, 1953, that I last saw the deceased alive on July 22, 1953, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

Dr. Williamson

M. D.

23B. ADDRESS

3334 Woodward St

23C. DATE SIGNED

7-25-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

July 28, 1953

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

BALTIMORE Md.

DATE RECEIVED BY LOCAL REGISTRAR

JUL 27 1953

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

George L. Schwab 2101 Frederick Ave

ADDRESS

VS 150

20158



MARGIN RESERVED FOR BINDING

PLEASE WRITE PRECISELY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

|  |                               |  |  |  |   |   |  |
|--|-------------------------------|--|--|--|---|---|--|
| F-635  |                               | F. FREUDENWALD   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 53 6773  |  |
| BIRTH NO. 53 6773  |                               | 1. NAME OF DECEASED (Type or Print) <b>Reuben Freudenwald</b>  |  |  |   | 2. DATE OF DEATH <b>July 26-1953</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Habited 6</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution / residence before admission)<br>A. STATE <b>Wisconsin</b><br>B. COUNTY <b>V-46</b> |  |  |   |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33 JOHNS HOPKINS HOSPITAL</b>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Caledonia</b>   |  |  |   |   |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                               | D. STREET ADDRESS (If rural, give location)<br><b>Reciene County</b>   |  |  |   |   |  |
| 5. SEX <b>male</b>   | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  | 8. DATE OF BIRTH <b>6-17-1900</b>  | 9. AGE (In years last birthday) <b>53</b> | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min.                     |  |
| 11. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)<br><b>Garage owner</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Wisconsin</b>            |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>John Freudenwald</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>Melia Zimmerman</b>   |  | 17. INFORMANT ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.<br><b>387-32-4508</b>  |  |  |   |   |  |
| 18. <b>581.0 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hepatic Failure</b>                 |                               | CAUSE OF DEATH<br>(A) <b>Hepatic Failure</b><br>DUE TO<br>(B) <b>Cirrhosis of the Liver</b><br>DUE TO<br>(C)                                 |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 yrs.</b>                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                               |  |  |  |   |   |  |
| II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                               |  |  |  |   |   |  |
| 19A. DATE OF OPERATION<br><b>July 21, 1953</b>   |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Esophageal Varices</b>  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                    |  | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 15, 1953</b> , to <b>July 26, 1953</b> , that I last saw the deceased alive on <b>July 26, 1953</b> , and that death occurred at <b>11 A m.</b> , from the causes and on the date stated above. |                               |  |  |  |   |   |  |
| 23A. SIGNATURE<br><b>William F. Freudenwald M.D.</b>   |                               | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  | 23C. DATE SIGNED   |   |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  |                               | 24B. DATE<br><b>7/26/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Reciene Wisconsin</b>           |   | 24D. LOCATION (City, town, or county) (State)<br><b>2024</b>                        |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 27 1953</b>   |                               | REGISTRAR'S SIGNATURE<br><b>Huntington</b>   |  | 25. FUNERAL DIRECTOR<br><b>Philip Henry Sme Orleans St</b>               |   | ADDRESS   |  |
| VS 150<br><b>29083</b><br><b>31</b>  |                               |  |  |  |   |   |  |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

State of New York

Blank form with horizontal lines for text entry.



S-200

CERTIFICATE AMENDED 8-6-53

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6774

53 6774

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SEICHE, MR. CLARENCE F. SEICHE

2. DATE  
OF  
DEATH

7-24-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland yes

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONS<sup>t</sup>. Agnes Hospital5. SEX  
M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
marriedYrs.  
Mos.  
Days10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Office Worker

10B. KIND OF BUSINESS OR  
INDUSTRY

DoNut Corp of America

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore, Md.

D. STREET ADDRESS (If rural, give location)

308 Frederick Ave. 28

8. DATE OF BIRTH

12-7-1891

9. AGE (In years  
last birthday)

61

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick A. Seiche

14. MOTHER'S MAIDEN NAME

Lipsy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.

215-10-5322

17. INFORMANT

Mrs Anna Seiche

ADDRESS

18. 200.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinomatosis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Retroperitoneal lymphosarcoma,  
(reticulum cell type)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10/53, 19, to 7/24/53, 19, that I last saw the  
deceased alive on 7/24/53, 19, and that death occurred at 9<sup>13</sup> P.m., from the causes and on the date stated above.

23A. SIGNATURE

B. Martin Middleton

M. D.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

7/28/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
BURIAL

24B. DATE

7/27/53

24C. NAME OF CEMETERY OR CREMATORY

LOUON PARK

24D. LOCATION (City, town, or county)

BALTO. MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

MAC NABBISON

ADDRESS

39044 CATONSVILLE RD

see query reply in Document file.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6775**

**1. NAME OF DECEASED**  
(Type or Print) **A. Estelle Rhine**

**2. DATE OF DEATH** **July 24, 1953**

**3. PLACE OF DEATH:**  
**A. Baltimore City, Maryland**

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
**A. STATE** **MD** **B. COUNTY** **BALTO.**

**5. FULL NAME OF** (If not in hospital or institution, give street address or location)  
**HOSPITAL OR INSTITUTION** **Pinecrest Sanatorium**

**6. CITY OR TOWN** (If outside corporate limits, write RURAL and give township)  
**CATONSVILLE**

**7. STREET ADDRESS** (If rural, give location)  
**601 COLEMAN AVE.**

**8. Length of stay in Baltimore** **3 yrs**

**9. SEX** **F** **10. COLOR OR RACE** **W** **11. SINGLE/MARRIED, WIDOWED, DIVORCED (Specify)** **WIDOW**

**12. DATE OF BIRTH** **11/18/1868** **13. AGE (In years last birthday)** **85**

**14. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Domestic** **15. KIND OF BUSINESS OR INDUSTRY** **at home**

**16. BIRTHPLACE** (State or foreign country) **MD** **17. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

**18. FATHER'S NAME** **Geo. F. Wideman** **19. MOTHER'S MAIDEN NAME** **Phyllis**

**20. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no or unknown) **11. SOCIAL SECURITY NO.** **12. INFORMANT** **Address**

**18. 420.1 I** **CAUSE OF DEATH** **INTERVAL BETWEEN ONSET AND DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **(A) Acute MYOCARDIAL INFARCTION 2 1/2 hrs**

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.** **(B) Coronary Artery Thromboses**

**(C) Coronary Arteriosclerosis? GENERALIZED ARTERIOSCLEROSIS?**

**II**

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.** **Senility**

**19A. DATE OF OPERATION** **0** **19B. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** **YES** ☐ **NO** ☒

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME (Month) (Day) (Year) (Hour) INJURY** **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

**WHILE AT WORK** ☐ **NOT WHILE AT WORK** ☐

**22. I hereby certify that I attended the deceased from MAY 11, 1950, to JULY 24, 1953, that I last saw the deceased alive on JULY 24, 1953, and that death occurred at 9:15 P.m., from the causes and on the date stated above.**

**23A. SIGNATURE** **Melvin N. Borden M.D.** **23B. ADDRESS** **5000 Old Frederick Road** **23C. DATE SIGNED** **7/24/53**

**24A. BURIAL, CREMATION, REMOVAL (Specify)** **BURIAL** **24B. DATE** **7/28/53** **24C. NAME OF CEMETERY OR CREMATORY** **ST. JOHN** **24D. LOCATION (City, town, or county) (State)** **ELLICOTT CITY, MD.**

**DATE RECEIVED BY LOCAL REGISTRAR** **REGISTRAR'S SIGNATURE** **25. FUNERAL DIRECTOR** **ADDRESS**

**MAC NABB & SON** **CATONSVILLE 28**

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

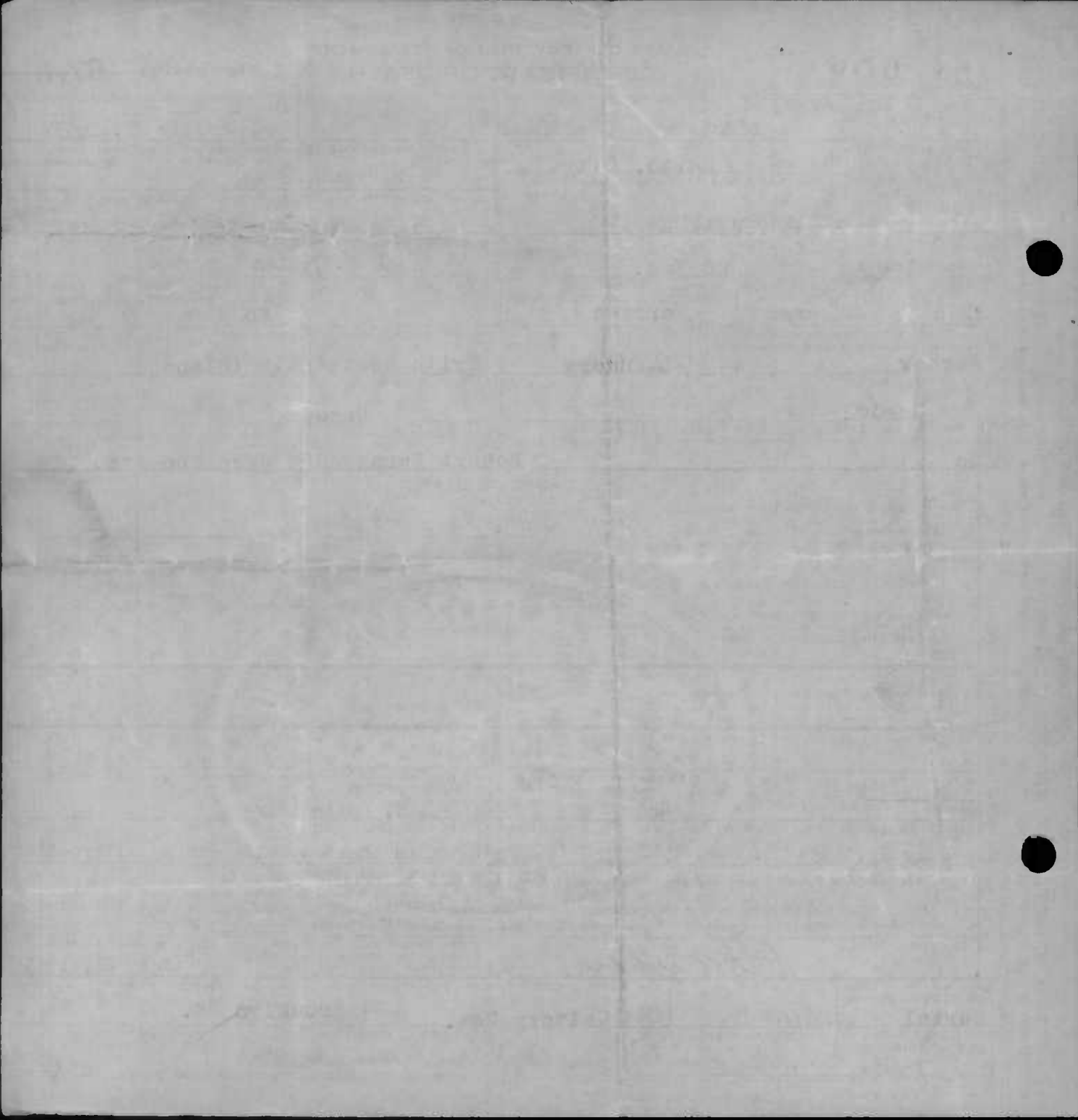
Registered No. 53 6776

53 6776  
BIRTH NO.

|   |                                 |  |  |  |   |
|---|---------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LEROY ROBINSON</b>  |                                 |  | 2. DATE OF DEATH <b>July 22, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>                                      |                                 |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hospital</b>                                   |                                 |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>                                  |  |   |
| c. Length of stay in Baltimore <b>20 Yrs.</b>   |                                 |  | D. STREET ADDRESS (If rural, give location) <b>904 N. Fulton Street</b>  |  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday) <b>45</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Washer</b> |                                 | 10B. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>               |  | 11. BIRTHPLACE (State or foreign country) <b>Brith West India Island</b> |   |
| 13. FATHER'S NAME <b>Unkown</b>   |                                 |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>                               |                                 |  | 16. SOCIAL SECURITY NO.  |  |   |
| 14. MOTHER'S MAIDEN NAME <b>Unkown</b>  |                                 |  | 17. INFORMANT ADDRESS <b>Robert Burns 3058 Ascension Ave.</b>  |  |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>E981X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Gunshot wound of chest</b><br>DUE TO (A) ..... |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (B) .....   |  |                                  |
| (C) .....  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>904 N. Fulton Street</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>July 21, 1953 6:00 P. m.</b>   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR? <b>Shot in chest by wife during altercation</b>                           |  |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |  |  |
| 23A. SIGNATURE <b>R. Fisher</b>   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED <b>July 22, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>726/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>  |  |
| 24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR  |  | 24F. REGISTRAR'S SIGNATURE <b>Thos. O. Wilson</b>  |  |
| 24G. FUNERAL DIRECTOR   |  | 24H. ADDRESS   |  | 24I. SIGNATURE <b>Wilson</b>   |  |



R-430

53 6777

IRTH NO.

KELLET  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6777  
Registered No.

NAME OF DECEASED  
(Type or Print)PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
STATION

Length of stay in Baltimore

SEX F. 6. COLOR OR RACE W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

A. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

FATHER'S NAME

D. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)

18. 420.0  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 1952, 19, to 7/25/53 19, that I last saw the deceased alive on 7/20/53, 19, and that death occurred at 7P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

4A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

811

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Religion \_\_\_\_\_

Usual Residence \_\_\_\_\_

Place of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Time of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

Manner of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 6778

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6778

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES L. CROUCH

2. DATE  
OF  
DEATH

7/24/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BATIMORE 25-04

649 PATAPSCO AVE (25)

D. STREET ADDRESS (If rural, give location)

649 PATAPSCO AVE (25)

c. Length of stay in Baltimore

LIFE

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

JULY 19, 1872

9. AGE (In years last birthday)

81

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

GUARD

10B. KIND OF BUSINESS OR INDUSTRY

MO. PENITENT

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOHN CROUCH

14. MOTHER'S MAIDEN NAME

? WILHELMENA RAISON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
MRS. BERNICE PATRYN SAME

18.

470.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC  
DUE TO HEART DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Robert Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 7-25-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7/28/53

24C. NAME OF CEMETERY OR CREMATORY

WESLEY CHAPEL

24D. LOCATION (City, town, or county) (State)

ROCK HALL MD.

DATE RECEIVED BY LOCAL REGISTRAR

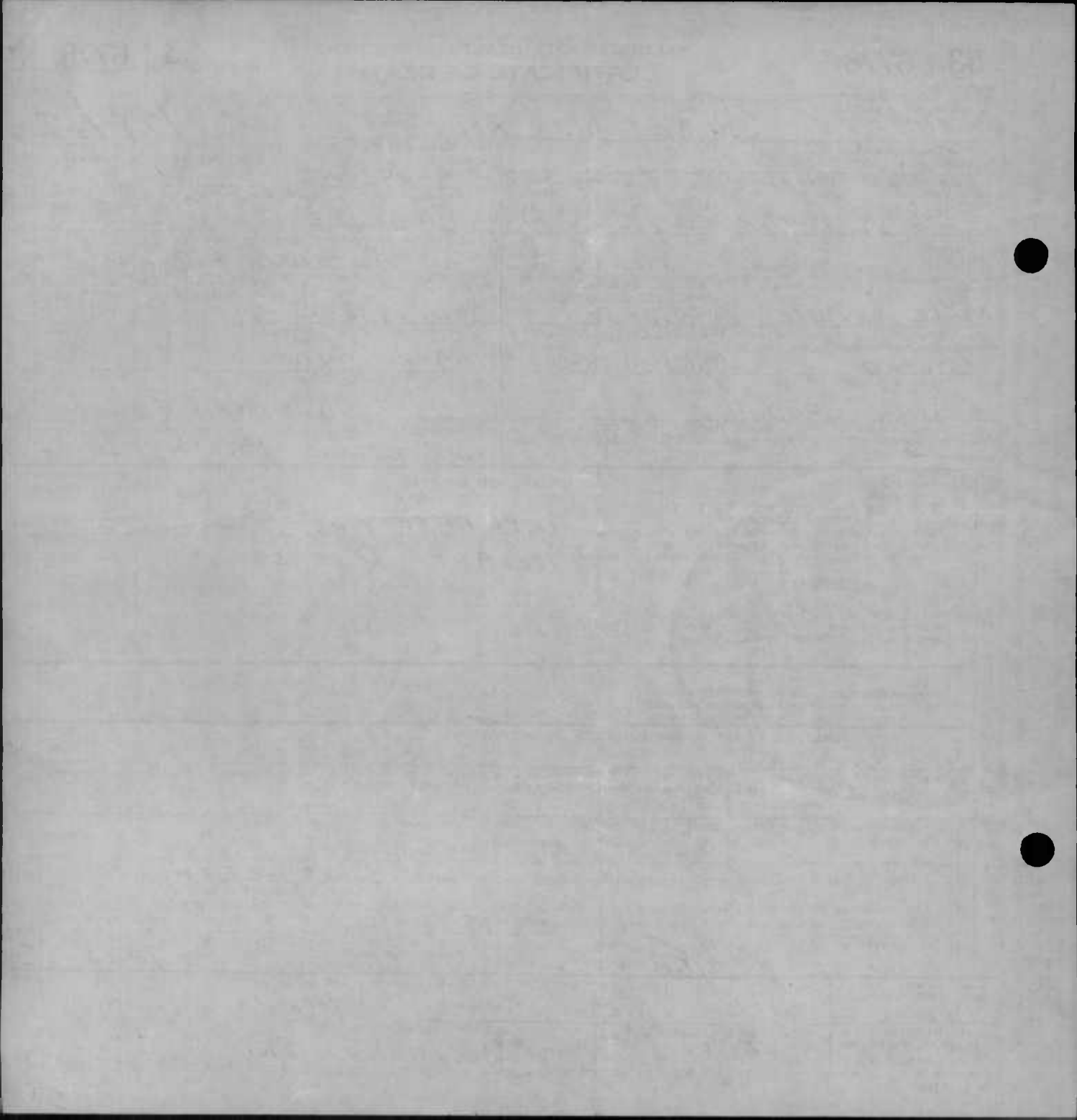
REGISTRAR'S SIGNATURE

Huntington Holmes, M.D.

25. FUNERAL DIRECTOR

JOHN F. DENNY, INC.

715 KIGHT ST. BALTO, 30, MD.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6779**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**CHYREA****CAMPBELL**2. DATE  
OF  
DEATH**7-24-53**3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION**W. H.**4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

**10** Yrs.  
Mos.  
Days

8. DATE OF BIRTH

**May 9-1913**9. AGE (In years  
last birthday)**40**

11 Under 1 Year

11 Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**Rough Painter**10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Home Virginia**12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Herbert Campbell**

14. MOTHER'S MAIDEN NAME

**Lucy Groves**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.**2-34-18-19**

17. INFORMANT

ADDRESS

**Viola Campbell 636 Melrose Ave**18. **E929.3**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **DROWNING**  
DUE TO

ANTECEDENT CAUSES

(B)   
DUE TODISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(C)   
DUE TOII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)**DRYDOCK**21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)**MARYLAND DRYDOCK****25-06**21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY**7 24 53 12**

21E. INJURY OCCURRED

WHILE AT ☒ WORK  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

**Fell from platform into water**22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thercon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**R. B. Fisher** M.D.23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**7-25-53**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**Burial**

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

**Home Cemetery**

24D. LOCATION (City, town, or county)

**Home**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

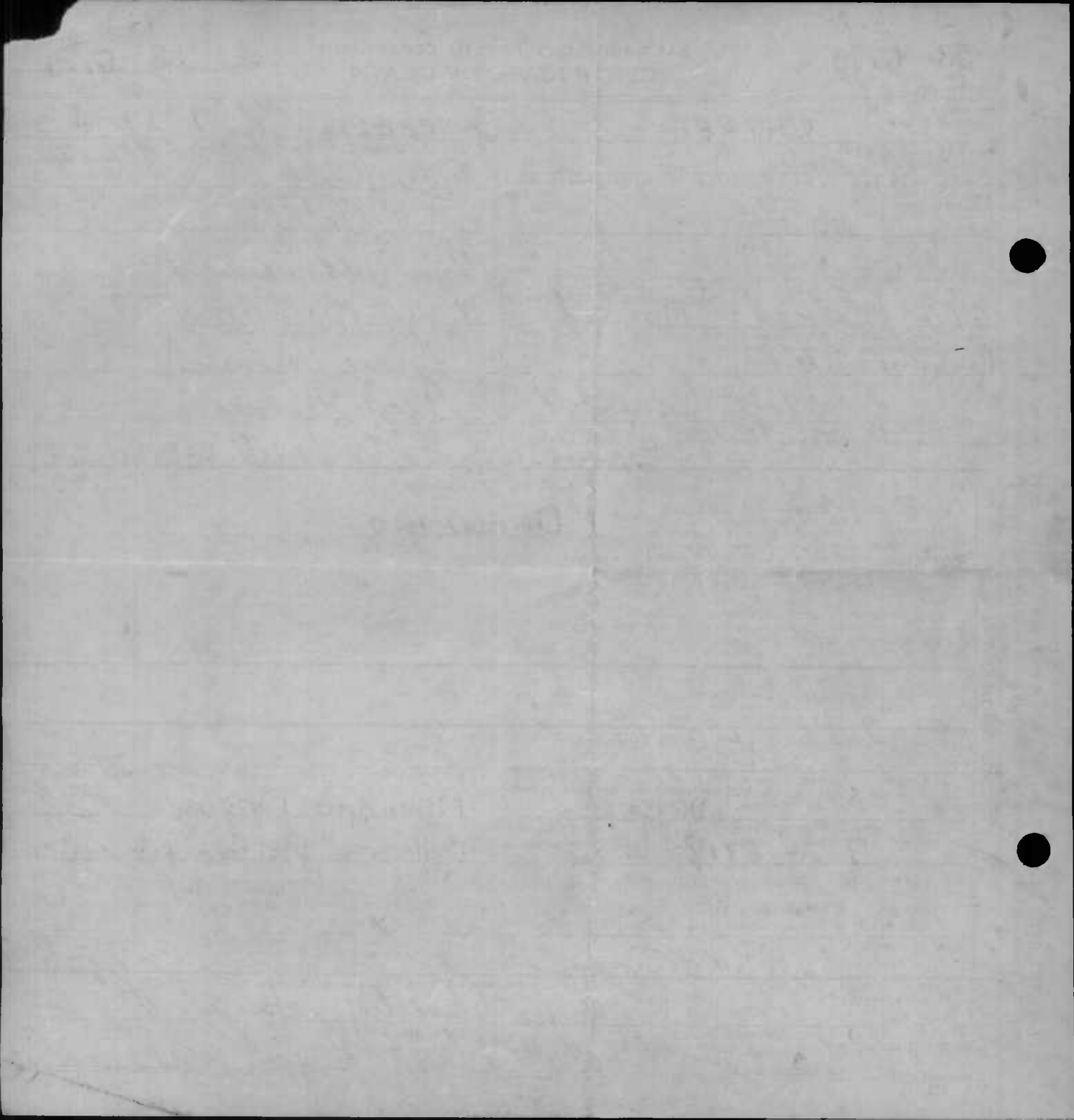
25. FUNERAL DIRECTOR

ADDRESS

**Brooks Ruggold 1463 N. Carey St**

VS 151

**N 990x****56424**



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-524

53 6780  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6780  
Registered No.

|   |                           |   |                                   |  |   |
|---|---------------------------|---|-----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | Mrs. Mary Elizabeth Winkler   |                                   | 2. DATE OF DEATH<br>July 26, 1953  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland |                                   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>2836 Lake Avenue   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore                     |                                   |  |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                           | D. STREET ADDRESS (If rural, give location)<br>2836 Lake Avenue   |                                   |  |   |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed  | 8. DATE OF BIRTH<br>Dec. 12, 1869 | 9. AGE (In years last birthday)<br>83                                    | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home  |                           | 10B. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland         |   |
| 13. FATHER'S NAME<br>Fréderrick Frey  |                           | 12. CITIZEN OF WHAT COUNTRY?  |                                   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.   |                                   | 14. MOTHER'S MAIDEN NAME<br>Theresa Soety                                |   |
| 17. INFORMANT<br>Mr. George J. Winkler  |                           | ADDRESS<br>3113 Dudley  |                                   |  |   |
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |                           | CAUSE OF DEATH<br>(A) Cerebral Hemorrhage<br>(B) Hypertension<br>(C) Atherosclerosis                          |                                   | INTERVAL BETWEEN ONSET AND DEATH<br>36 hours<br>yes<br>yes               |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |   |                                   |  |   |
| 19A. DATE OF OPERATION<br>0   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                     |                                   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from June 1946, to July 26, 1953, that I last saw the deceased alive on July 25, 1953, and that death occurred at 5A m., from the causes and on the date stated above.  |                           |   |                                   |  |   |
| 23A. SIGNATURE<br>Carlton L. Reno   |                           | 23B. ADDRESS<br>3025 Belair Road  |                                   | 23C. DATE SIGNED<br>7-27-53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>July 29, 1953  |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                 |   |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Maryland  |                           | 24E. FUNERAL DIRECTOR<br>Leonard J. Ruck  |                                   |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 27 1953   |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, Jr.   |                                   | ADDRESS<br>5305 Harford Road.  |   |





W-410  
53 6781BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6781  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Mary Agnes Wolf

2. DATE  
OF  
DEATH July 25, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1559 Abbottston Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1559 Abbottston Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Mar. 29, 1861

9. AGE (In years  
last birthday)

92

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
at home10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Mc Laughlin

14. MOTHER'S MAIDEN NAME

Ann Mc Carthy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mrs. Sadie B. Wolf, 1559 Abbottston

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Cardiac failure*  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Generalized cardiac - vascular disease*  
DUE TO  
(C) *with arteriosclerosis.*

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN, 1952, to 25 July, 1953, that I last saw the  
deceased alive on 25 July, 1953, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

*Carlton Brinfield*

M. D.

23B. ADDRESS

422 Medical Arts Building

23C. DATE SIGNED

7-25-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 28, 1953

Holy Redeemer Cem. Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Huntington Ave. ...*

Leonard J. Ruck, 5305 Harford Road.

VS 150

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Bristol  
Zimmerman Office  
Harford Road

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 8-10-53

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6782  
Registered No.

BIRTH NO.

|  |                               |  |   |  |   |
|--|-------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Anthony Petrone Patapar</b>  |                               |  | 2. DATE OF DEATH<br><b>July 26, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3022 Grindon Ave</b>   |                               |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-02</b>                    |  |   |
| c. Length of stay in Baltimore<br>Yrs. <b>00</b><br>Mos.<br>Days   |                               |  | D. STREET ADDRESS (If rural, give location)<br><b>3022 Grindon Ave</b>  |  |   |
| 5. SEX<br><b>M.</b>  | 6. COLOR OR RACE<br><b>W.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid.</b> | 8. DATE OF BIRTH<br><b>Feb-2-1865</b>   | 9. AGE (In years last birthday)<br><b>88</b> | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer - Ret.</b>    |                               | 10B. KIND OF BUSINESS OR INDUSTRY                              | 11. BIRTHPLACE (State or foreign country)<br><b>Lithuania</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Lith.</b>                    |
| 13. FATHER'S NAME<br><b>Samuel Patapar</b>   |                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Agatha Unknown</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No-</b> |                               | 16. SOCIAL SECURITY NO.<br><b>None</b>                         | 17. INFORMANT ADDRESS<br><b>Helen DeVane - 3022 Grindon Ave</b>   |  |   |

|  |  |  |
|--|--|--|
| 18. <b>442X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Uremia, Cardis - Renal -</b><br>DUE TO <b>Arteriosclerotic Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>osteomyelitis of foot</b><br>DUE TO <b>Anterior Arteriosclerosis</b><br><b>Uremia</b><br>DUE TO <b>Arteriosclerotic Disease</b>                             |  | <b>2 yrs</b>                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **July 20**, 1953, to **July 26**, 1953 that I last saw the deceased alive on **July 25**, 1953 and that death occurred at **2:07 p.m.**, from the causes and on the date stated above.

|   |   |  |  |
|---|---|--|--|
| 23A. SIGNATURE<br><b>Newland Edward Day</b> M.D.            |   | 23B. ADDRESS<br><b>4-E-33rd St Balt 18</b>                   | 23C. DATE SIGNED<br><b>July 26, 1953</b>                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24B. DATE<br><b>7/27/53</b>                               | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Schenectady - N.Y.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 27 1953</b>      | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>Wm Cook Inc Balto-</b>    |  |

Handwritten notes at the top of the page, including the date "1952" and the word "History".

Handwritten notes in the middle section, including the words "History", "1952", and "History".

Handwritten notes at the bottom of the page, including the words "History", "1952", and "History".

53 6783

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6783

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GROVER A. ADAMS

2. DATE  
OF  
DEATH July 23, 19533. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Maryland B. COUNTY before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

D. STREET ADDRESS (If rural, give location)

2803 Maisel Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Mar 30 - 1898

9. AGE (In years  
last birthday)

55

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Sheet metal worker

10B. KIND OF BUSINESS OR  
INDUSTRY

Sheet Metal

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Adams

14. MOTHER'S MAIDEN NAME

Mary Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

218-05-1692

17. INFORMANT

ADDRESS

Edna Adams - 2803 Maisel St

18. 420.1 and 002x  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary artery sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23. SIGNATURE

Joseph A. Jachimczyk

M.D.

23b. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED

July 24, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 27-

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 27 1953

Frank E. Hines

1217 St Paul St

See Document file for directive from

Dr. Jos. A. Jachimczyk, Asst. Med. Exam., Baltimore, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6784  
Registered No.

BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Elsie F. Koehler</b>  |                                  | 2. DATE OF DEATH<br><b>July 24, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2911 Miles Avenue</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2911 Miles Avenue</b>  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>  | 8. DATE OF BIRTH<br><b>Dec. 18, 1894</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   | 9. AGE (In years last birthday)<br><b>56</b> |
| 13. FATHER'S NAME<br><b>Richard Miller</b>  |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)                              |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mrs. Shirley Shipley, 2911 Miles Avenue</b>   |                                  | ADDRESS  |  |

|   |   |  |   |
|---|---|--|---|
| 18. <b>153 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma Colon</b><br>(A) DUE TO<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C) DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs ±</b>                       |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>19 July</b> , 19 <b>53</b> , to <b>24 July</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>22 Jul</b> , 19 <b>53</b> , and that death occurred at <b>7:20 A.M.</b> , from the causes and on the date stated above.  |   |  |   |
| 23A. SIGNATURE<br><i>[Signature]</i>  | 23B. ADDRESS<br><b>2020 N Charles St</b>  | 23C. DATE SIGNED<br><b>24 July 53</b>                                    |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 24B. DATE<br><b>7/27/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>      | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b>          |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>VS 150</b>   | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   | 25. FUNERAL DIRECTOR<br><b>Wm. Ark. Inc., 1217 St. Paul Street</b>       |   |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 6785

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6785  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Emma V. Bowen</b>   |                                  |   | 2. DATE OF DEATH <b>July 24, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1003 Brentwood Avenue</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>                                    |  |   |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1003 Brentwood Avenue</b>  |  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>May 4, 1882</b>   |  | 9. AGE (In years, last birthday)<br><b>71</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>              | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br>_____         |
| 13. FATHER'S NAME<br><b>Watson Webb</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Eleanor Nolan</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____   |                                  | 16. SOCIAL SECURITY NO. _____                                     | 17. INFORMANT ADDRESS<br><b>Ruth Green, 1003 Brentwood Avenue</b>  |  |   |

|   |  |   |
|---|--|---|
| 18. <b>153X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br><b>Cancer of intestines</b><br>(A) _____<br>DUE TO<br><b>Cardiovascular Disease</b><br>(B) _____<br>DUE TO<br><b>Senility. Generalized arteriosclerosis</b><br>(C) _____   | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>years</b><br><br><b>many years</b><br><br><b>years</b> |
|   | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |
|   | 19A. DATE OF OPERATION _____<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____<br>19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____<br>19D. HOW DID INJURY OCCUR? _____<br>19E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>19F. HOW DID INJURY OCCUR? _____ |   |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19A. DATE OF OPERATION _____  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____   |  | 19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____ |  | 19D. HOW DID INJURY OCCUR? _____                      |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____ |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR? _____   |  | 21G. DATE SIGNED _____   |  | 21H. SIGNATURE _____                                  |  |

22. I hereby certify that I attended the deceased from **7/23/53**, 19\_\_, to **7/24/53**, 19\_\_, that I last saw the deceased alive on **7/23/53**, 19\_\_, and that death occurred at **6:00 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Henry Armas M.D.** 23B. ADDRESS **1934 Wilkens Ave. Balt. Md.** 23C. DATE SIGNED \_\_\_\_\_

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> |  | 24B. DATE<br><b>7/27/53</b>                         |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR _____                     |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>St. M. Cook, Inc.</b>               |  | ADDRESS<br><b>1217 St. Paul Street</b>                                     |  |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6786  
Registered No.53 6786  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

EVERETT ROWLAND

2. DATE  
OF  
DEATH

7/25/53

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE

Md 5002

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1115 McEldery St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1115 McEldery St

c. Length of stay in Baltimore

5. SEX

Male Negro

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

4-10-96 57

9. AGE (in years  
last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Waiter

10B. KIND OF BUSINESS OR  
INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Apex, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Roland

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or date of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Luther Johnson, 1523 McCallum St

18. 443x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial Insufficiency

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)

Hypertensive Heart Disease

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

J. B. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
7/25/5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7/27/53

Mt. Auburn

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

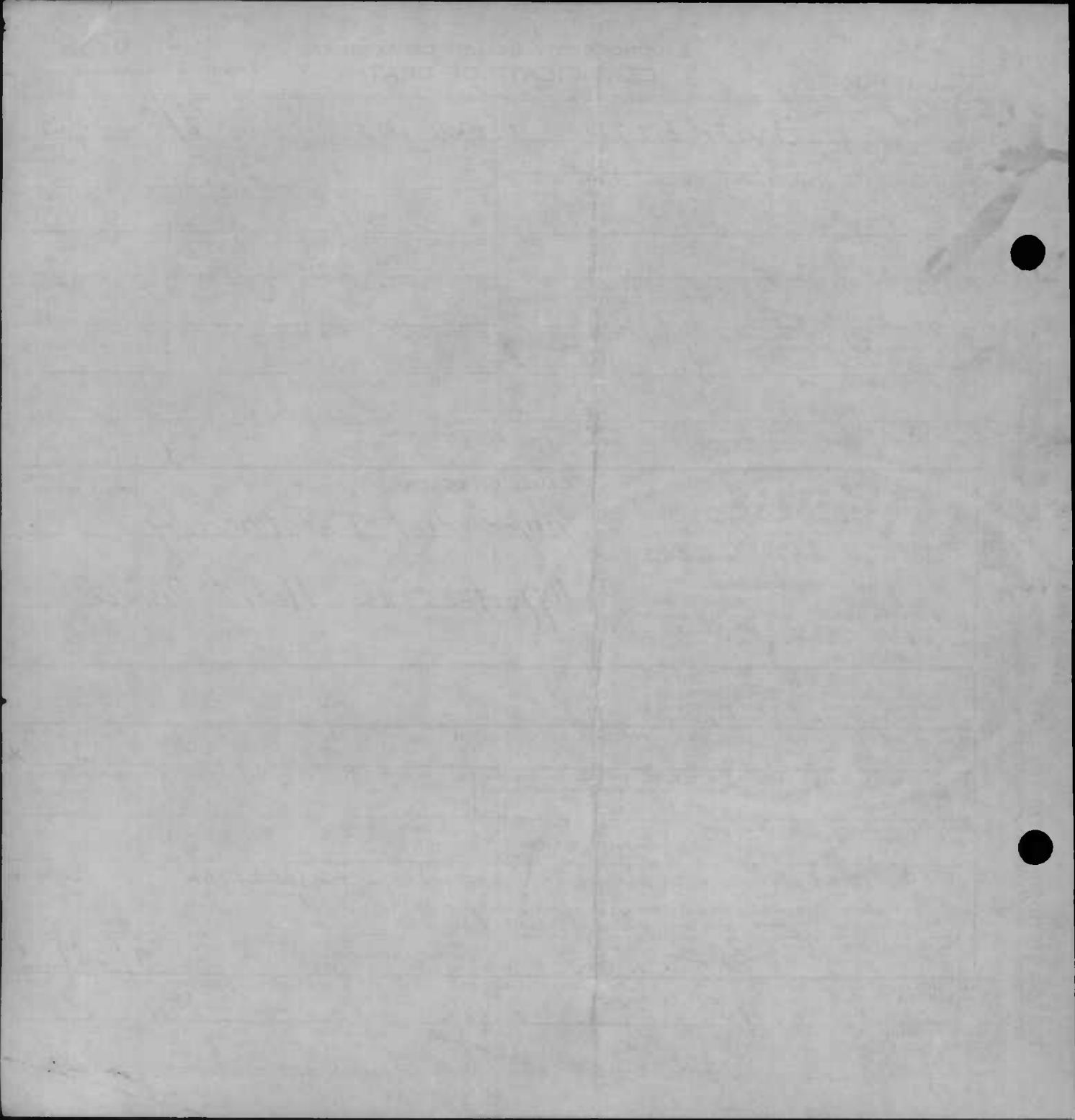
25. FUNERAL DIRECTOR

ADDRESS

7/27/53

Huntington Williams, M.D.

Charles L. Law, 802 Mad. Ave.





R-100  
53 6787BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6787

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GRAYSON RUBY

2. DATE  
OF  
DEATH

7/25/53

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MdB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Union Memorial Hospital Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1120 24 38th 13-07

c. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Feb 24 - 1896

9. AGE (In years last birthday)

37

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cement worker

10B. KIND OF BUSINESS OR INDUSTRY

Concrete work

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William R Ruby

14. MOTHER'S MAIDEN NAME

Clara Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

I.W.W.

16. SOCIAL SECURITY NO.

2817-05-3024

17. INFORMANT

Marie S Ruby 1120 24 38th

ADDRESS

18. 002X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. F. Fisher

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

23C. DATE SIGNED

7/25/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

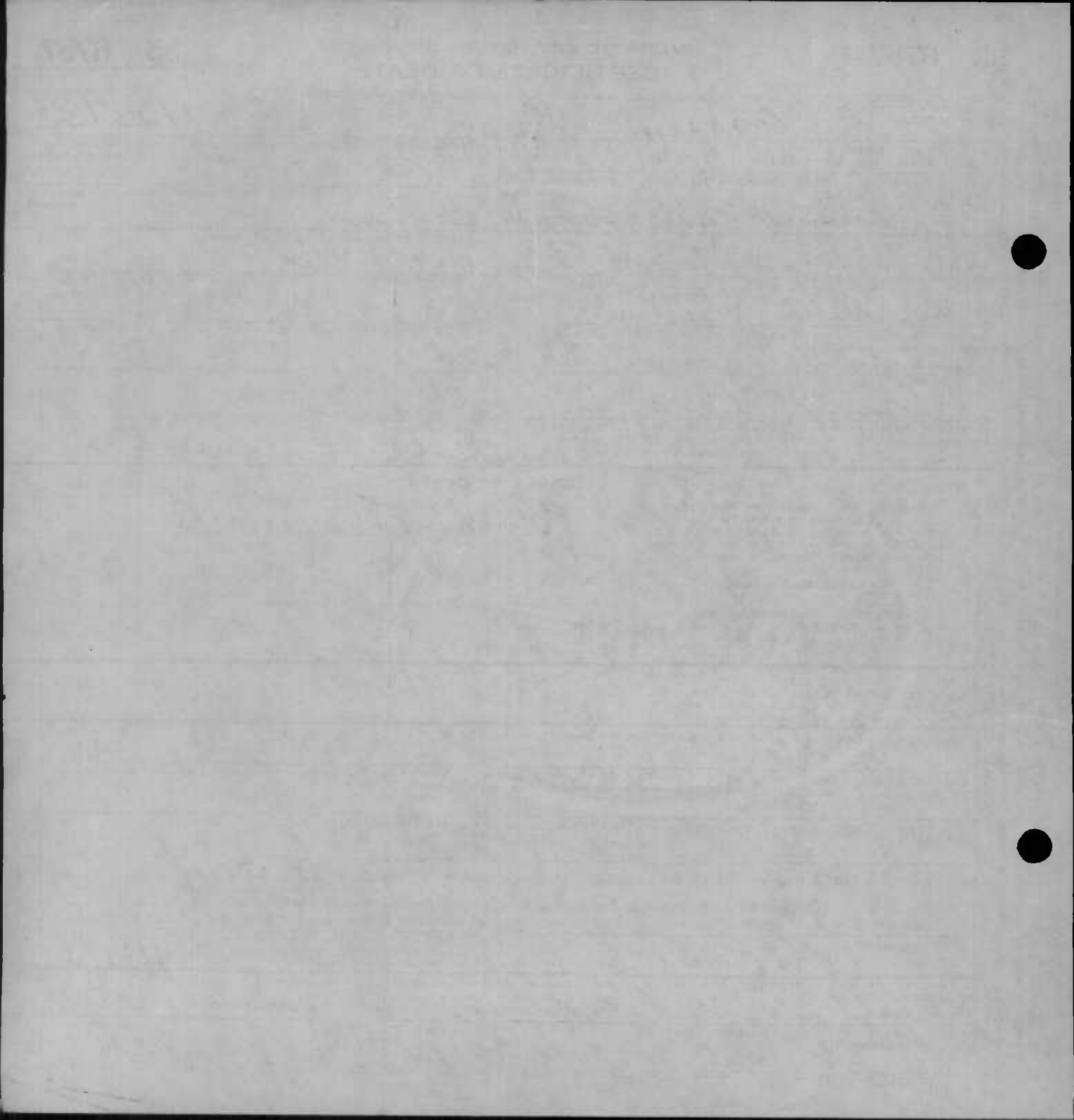
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

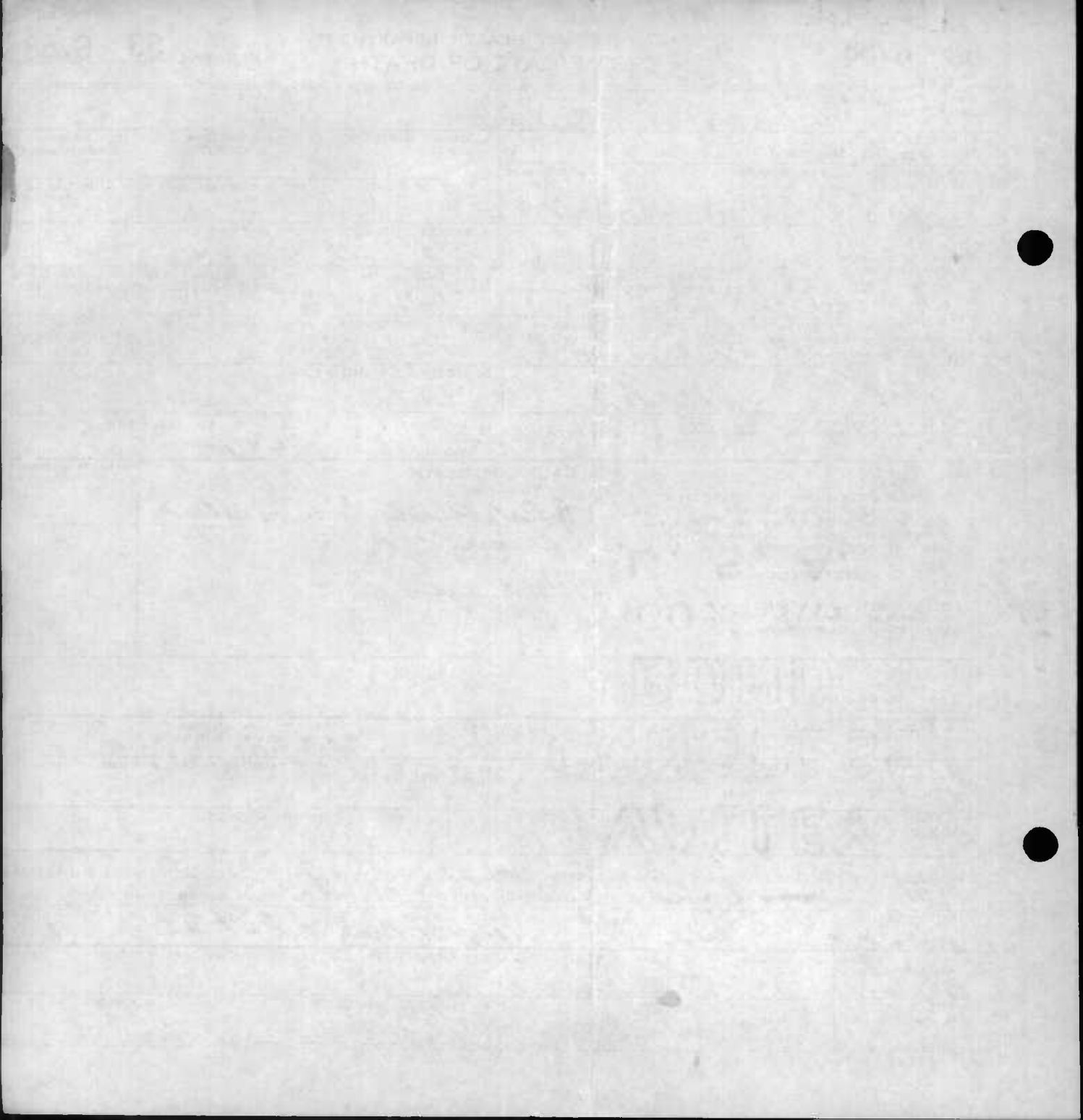
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



|  |                                  |   |  |  |  |   |                                  |
|--|----------------------------------|---|--|--|--|---|----------------------------------|
| W-536  |                                  | 1101 St. Paul St. Ue 7-0340   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 53 6788  |                                  |
| 53 6788  |                                  | BIRTH NO.   |  | CERTIFICATE OF DEATH   |  |   |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>John Henry Winder</i>  |                                  |   |  | 2. DATE OF DEATH<br><i>7/24/53</i>   |  |   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY |  |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>80 103 W. Monument st</i>   |                                  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. 11-02</i>                    |  |   |                                  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  |   |  | D. STREET ADDRESS (If rural, give location)<br><i>103 W. Monument st.</i>  |  |   |                                  |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   |  | 8. DATE OF BIRTH<br><i>8/23/1862</i>   | 9. AGE (in years last birthday)<br><i>90</i> | If Under 1 Year<br>Months: Days   | If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Port Manager</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Seaboard R.R.</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Raleigh N.C.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?  |                                  |
| 13. FATHER'S NAME<br><i>John Winder</i>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Octavia Bryan</i>   |  |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Elizabeth M. Winder</i> <i>103 W. Monument st</i>  |  |   |                                  |
| 18. <i>4 yr. 1</i> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Anteriosclerotic Cardiovascular</i><br>DUE TO <i>disease</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Old age</i><br>DUE TO<br>(C) |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |  |  |  |   |                                  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |   |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |                                  |
| 22. I hereby certify that I attended the deceased from <i>now 31</i> 19 <i>53</i> , to <i>July 24</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>May 18</i> , 19 <i>53</i> , and that death occurred at <i>6:00</i> A. M., from the causes and on the date stated above.  |                                  |   |  |  |  |   |                                  |
| 23A. SIGNATURE<br><i>George S. Watson</i> M. D.  |                                  |   |  | 23B. ADDRESS<br><i>1101 St. Paul St. Balt. Md.</i>   |  | 23C. DATE SIGNED<br><i>July 28, '53</i>   |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 24B. DATE<br><i>7/27/53</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Green Mount</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>                  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |  | 25. FUNERAL DIRECTOR<br><i>Wm. Cook Inc.</i>   |  | ADDRESS<br><i>1217 St. Paul St.</i>   |                                  |
| JUL 27 1953  |                                  |   |  |  |  |   |                                  |



D-452

3 6789

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6789  
Registered No.NAME OF DECEASED  
(Last, first, middle, or Print)

JOSEPH DAKINSKY

2. DATE  
OF  
DEATH

7-26-53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3932 Annelawn Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md

B. COUNTY

15-11

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3932 Annelawn Road

Length of stay in Baltimore

41

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR  
INDUSTRY

mens Cape

8. DATE OF BIRTH

9. AGE (In years  
last birthday)11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Israel

14. MOTHER'S MAIDEN NAME

Kaska

13. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Jennie Dakinsky - Same

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coarctation of Aorta

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Atherosclerotic Changes - Coronaries  
Heart Disease

?

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/16, 1953, to 7/26, 1953, that I last saw the  
deceased alive on 7/26, 1953, and that death occurred at 5:41 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph S. Blum

M. D.

23B. ADDRESS

1115 N. Calver St

23C. DATE SIGNED

7/27/53

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

7-27-53

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county) (State)

Baltimore

Md

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

2906 E 2100 Canton Pl

VS 150

2906 E

Jos Blum  
115 910 Colored

MW 5 4777

707-0444  
3513 Powhattan Ave



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6790**

**3** TH NO. **6790**

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Last, first, middle, or Print) <b>Snavelly, Charles G.</b> |  | 2. DATE OF DEATH <b>24 July 1953</b>  |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>BALTO</b> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>          |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baldwin, Md.</b>   |  |
| 6. Length of stay in Baltimore   |  | D. STREET ADDRESS (If rural, give location)   |  |

|  |                              |   |  |  |  |                                  |
|--|------------------------------|---|--|--|--|----------------------------------|
| SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>21 Feb. 1860</b>                      | 9. AGE (In years last birthday)<br><b>93</b> | If Under 1 Year<br>Months: Days: Hours: Min. | If Under 24 Hours<br>Hours: Min. |
| 10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>Farmer</b> |                              |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |
| 13. FATHER'S NAME<br><b>John Henry Snavelly</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Lydia Donaldson</b>           |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>              |                              |   | 16. SOCIAL SECURITY NO.                                      |  |  |                                  |
| 17. INFORMANT<br><b>Dr. Guy Snavelly</b>   |                              |   | ADDRESS<br><b>2122 Maryland Ave. N.E.</b>                    |  |  |                                  |

|  |                |
|--|----------------|
| B. <b>470.0 and E 902.0</b>  | CAUSE OF DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                |
| (A) <b>Arteriosclerotic Heart Disease</b>  |                |
| DUE TO   |                |
| ANTECEDENT CAUSES  |                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                |
| (B) <b>Generalized Arteriosclerosis</b>  |                |
| DUE TO   |                |
| (C) <b>Joseph G. Huntington, M.D.</b>  |                |
| CHIEF OR ASST. MEDICAL EXAMINER  |                |

|   |  |
|---|--|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
| <b>(1) Fracture Left Hip (2) Hypoproteinemia</b>  |  |

|  |   |   |
|--|---|---|
| 9A. DATE OF OPERATION<br><b>0</b>  | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><b>NO</b> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>           | 21C. WHERE DID INJURY OCCUR?<br><b>Baldwin, Md.</b>                                 |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute)<br><b>July 19 1953</b>    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><b>Fell from chair</b>                                |

22. I hereby certify that I attended the deceased from **20 July, 1953**, to **24 July, 1953**, that I last saw the deceased alive on **24 July, 1953**, and that death occurred at **8 P.M.**, from the causes and on the date stated above.

|  |  |   |  |
|--|--|---|--|
| 23A. SIGNATURE<br><b>Thos. A.E. Monahan, M.D.</b>          | 23B. ADDRESS<br><b>Union Memorial Hosp</b>   | 23C. DATE SIGNED<br><b>24 July 53</b>                     | 24. LOCATION (City, town, or county) (State)<br><b>Fork Md.</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 24B. DATE<br><b>July 27-53</b>               | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Fork M. Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Fork Md.</b> |
| 25. FUNERAL DIRECTOR<br><b>Huntington Memorial</b>         | ADDRESS<br><b>W.E. E. Gutterman Fork Md.</b> |   |  |

VS. 150  
**N-870.0**

DEPARTMENT OF HEALTH  
OFFICE OF DEATH

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

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1951

1952

1953

1954

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1958

1959

1960

625  
3 6791

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6791

TH NO.

NAME OF DECEASED  
(Name or Print)

GRAYSON Mr. James

2. DATE  
OF  
DEATH

July 25, 1953

PLACE OF DEATH:

Baltimore City, Maryland

Balto. city

3. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St Josephs Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Balto

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto City

14-03

6. STREET ADDRESS (If rural, give location)

1936 Mc Culloh St. #17

7. Length of stay in Baltimore

Yrs.  
Mos.  
Days

8. SEX

Male

9. COLOR OR RACE

Colored

10. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

11. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

Hat Rack Man

12. KIND OF BUSINESS OR  
INDUSTRY

Hotel

Chalfonte Haddon Hall

13. DATE OF BIRTH

June 15, 1876

14. AGE (In years  
last birthday)

77

15. If Under 1 Year  
Months: Days

16. If Under 24 Hours  
Hours: Min.

17. BIRTHPLACE (State or foreign country)

Maryland

18. CITIZEN OF  
WHAT COUNTRY?

19. FATHER'S NAME

Jacob Grayson

20. MOTHER'S MAIDEN NAME

Mary Colbert

21. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No or unknown

22. SOCIAL  
SECURITY NO.

23. INFORMANT

ADDRESS

Leo Grayson-1936 McCulloh St.

24.

CAUSE OF DEATH

25. INTERVAL BETWEEN  
ONSET AND DEATH

26. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Hypertensive Cardio Vascular Disease

(A) DUE TO

27. ANTECEDENT CAUSES

Uremia

(B) DUE TO

28. DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

29.

30. OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

31. DATE OF OPERATION

June 12, 1953

32. MAJOR FINDINGS OF OPERATION

Right inguinal hernia

33. AUTOPSY?

YES ☐ NO ☒

34. 1. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

35. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

36. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

37. 1. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

38. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

39. HOW DID INJURY OCCUR?

40. I hereby certify that I attended the deceased from June 9, 1953 to July 24, 1953 that I last saw the deceased alive on July 24, 1953, and that death occurred at 12:00 m., from the causes and on the date stated above.

41. SIGNATURE

42. ADDRESS

St. Joseph's Hospital

43. DATE SIGNED

July 25, 1953

44. BURIAL, CREMA-  
REMOVAL (Specify)

45. DATE

46. NAME OF CEMETERY OR CREMATORY

47. LOCATION (City, town, or county)

48. (State)

49. RECEIVED BY  
AL REGISTRAR

50. REGISTRAR'S SIGNATURE

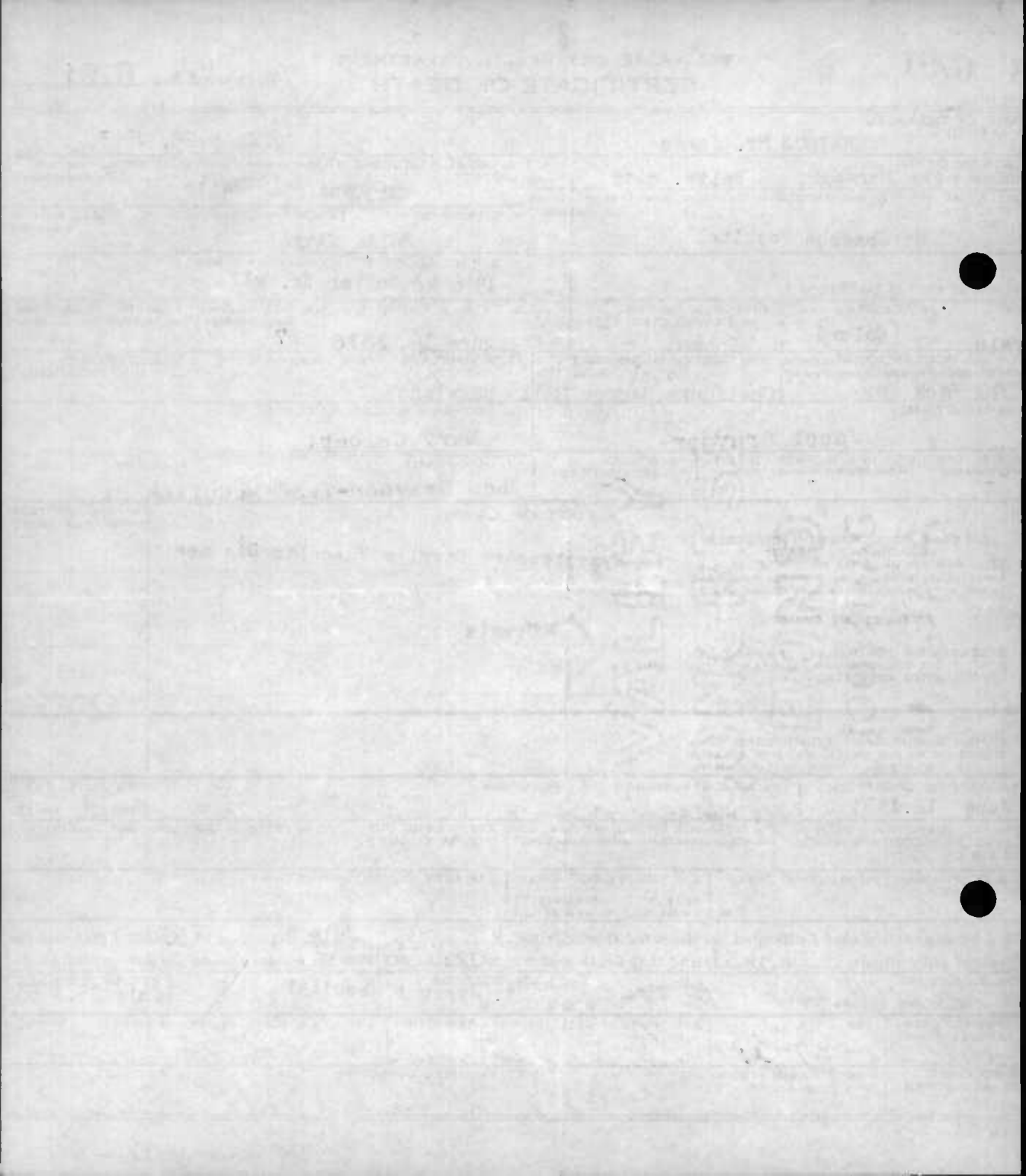
51. FUNERAL DIRECTOR

52. ADDRESS

53. 27 1953

VS 150

1011 N. Arlington Ave



MARGIN RESERVED FOR BINDING

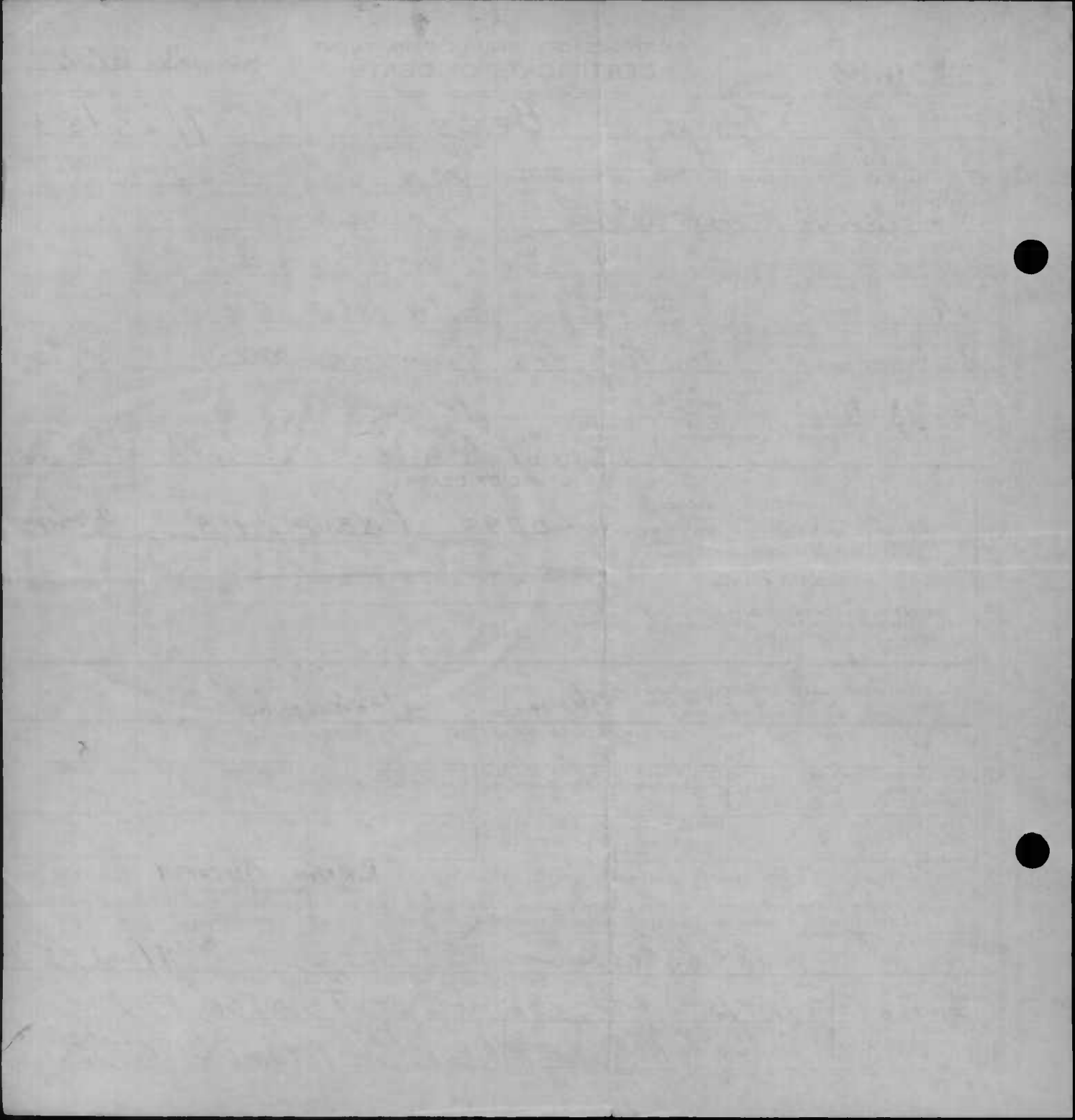
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6792

BIRTH NO. 53 6792

|  |                  |  |   |
|--|------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE OF DEATH   |   |
| Joseph Bess  |                  | 7/25/53  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                    |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)   |                  | A. STATE B. COUNTY   |   |
| Johns Hopkins  |                  | Md. Baltimore  |   |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |                  | D. STREET ADDRESS (If rural, give location)  |   |
| TOWSON   |                  | YORK ROAD  |   |
| c. Length of stay in Baltimore   |                  | 8. DATE OF BIRTH   |   |
| Yrs. Mos. Days   |                  | April 4, 1895 58   |   |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 9. AGE (in years last birthday)           |
| M  | C                | Single   | 58  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) |
| Laborer  |                  | Contractors  | TOWSON, Md.                               |
| 12. CITIZEN OF WHAT COUNTRY?   |                  | 13. FATHER'S NAME  |   |
| O. S. B.   |                  | Benjamin Bess  |   |
| 14. MOTHER'S MAIDEN NAME   |                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                 |   |
| UNKNOWN  |                  | NO   |   |
| 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |   |
| UNKNOWN  |                  | Bessie Bess Luther (116, Md)   |   |
| 18. 490x and 322.1   |                  | CAUSE OF DEATH   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                  | (A) LOBAR PNEUMONIA  |   |
| DUE TO   |                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 24hrs  |                  |  |   |
| ANTECEDENT CAUSES  |                  | (B)  |   |
| DUE TO   |                  |  |   |
| (C)  |                  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  | Chronic alcoholism   |   |
| 19A. DATE OF OPERATION   |                  | 19B. MAJOR FINDINGS OF OPERATION   |   |
|  |                  |  |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  |  |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                  |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |   |
| 21F. HOW DID INJURY OCCUR?   |                  |  |   |
| 22. I certify that I took charge of the remains described above, held an <u>Barrie Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |                  |  |   |
| 23A. SIGNATURE   |                  | 23B. CHIEF MEDICAL EXAMINER... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR... <input type="checkbox"/> |   |
| 23C. DATE SIGNED   |                  | 7/26/53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                  | 24B. DATE  |   |
| Burial   |                  | 7/27/53  |   |
| 24C. NAME OF CEMETERY OR CREMATORY   |                  | 24D. LOCATION (City, town, or county) (State)  |   |
| Pleasant Rest  |                  | TOWSON, Md.  |   |
| DATE RECEIVED BY LOCAL REGISTRAR   |                  | 25. FUNERAL DIRECTOR ADDRESS   |   |
| 21/2/53  |                  | Huntington, William, M.D. I. Chatman, Jr. 1701 Mt. Vernon St.  |   |





540  
6793

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6793

TH NO.

NAME OF DECEASED (Please print) *Martha T. Donnell*

2. DATE OF DEATH *7/24-53*

PLACE OF DEATH: *Baltimore City, Maryland*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *2143 Division St.* B. COUNTY *14-03*

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore*

6. STREET ADDRESS (If rural, give location)  
*2143 Division St.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Married*

8. DATE OF BIRTH *Sept 8, 1874*

9. AGE (In years last birthday) *78*

10. UNDER 1 Year Months Days 11. UNDER 24 Hours Hours Min.

12. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

13. BIRTHPLACE (State or foreign country)  
*Kidgeway, W.C.*

14. MOTHER'S MAIDEN NAME  
*Susan German*

15. FATHER'S NAME  
*Plummer Johnson*

16. SOCIAL SECURITY NO.

17. DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

18. CAUSE OF DEATH  
*Central Apoplexy & Paralysis*

19. INTERVAL BETWEEN ONSET AND DEATH

20. ANTECEDENT CAUSES

21. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

23. DATE OF OPERATION

24. MAJOR FINDINGS OF OPERATION

25. AUTOPSY? YES ☐ NO ☐

26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

29. TIME (Month) (Day) (Year) (Hour) OF INJURY

30. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

31. HOW DID INJURY OCCUR?

32. I hereby certify that I attended the deceased from *3/15* 19*53*, to *7/24* 19*53*, that I last saw the deceased alive on *7/23* 19*53*, and that death occurred at *P.A.* m., from the causes and on the date stated above.

33. SIGNATURE *B. M. R. H. H. H.* 34. ADDRESS *2139 Division St.* 35. DATE SIGNED *7/24-53*

36. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 37. DATE *July 28, 1953* 38. NAME OF CEMETERY OR CREMATORY *St. John* 39. LOCATION (City, town, or county) *Baltimore* 40. STATE *Md*

41. RECEIVED BY REGISTRAR'S SIGNATURE *Huntington Williams, Jr.* 42. FUNERAL DIRECTOR'S SIGNATURE *1601 David Hill Ave*

VS 150



-152  
3 6794

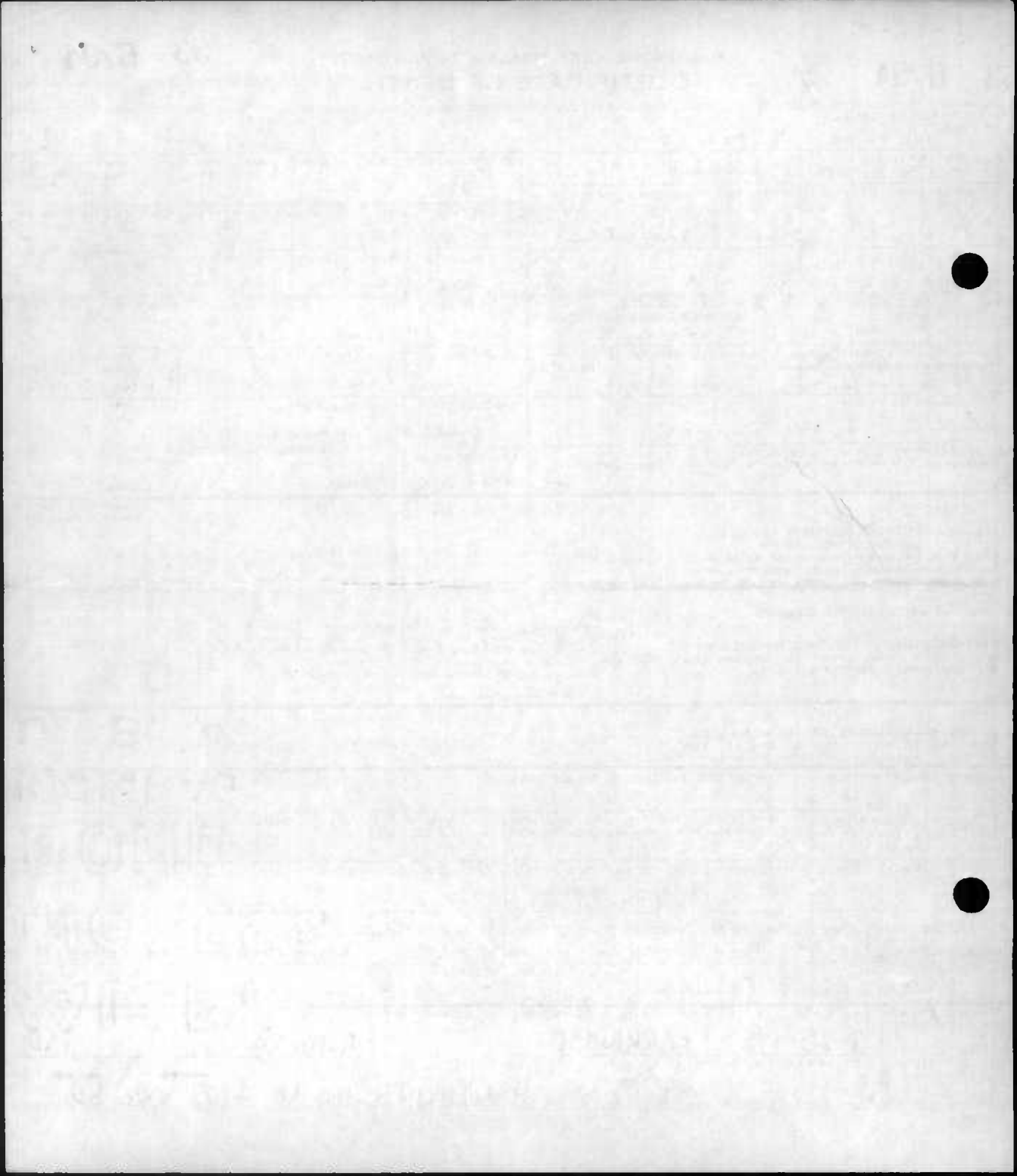
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6794  
Registered No.

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><i>Nettie Robinson</i>  |                              | 2. DATE OF DEATH<br><i>July 26, 1953</i>  |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <i>Baltimore, Md.</i><br>b. (If not in hospital or institution, give street address or location)<br><i>Maryland General Hospital</i> |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>Baltimore</i> |   |
| 5. Length of stay in Baltimore <i>Life</i>   |                              | 6. STREET ADDRESS (If rural, give location)<br><i>302 Radnor Ave. # 12</i>  |   |
| 7. SEX<br><i>F</i>   | 8. COLOR OR RACE<br><i>W</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 10. DATE OF BIRTH<br><i>June 25, 1880</i> |
| 11. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><i>House wife</i>   |                              | 12. AGE (In years last birthday)<br><i>73</i>   |   |
| 13. FATHER'S NAME<br><i>William T. Kinnamon</i>  |                              | 14. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>   |                              | 16. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |   |
| 17. SOCIAL SECURITY NO.  |                              | 18. MOTHER'S MAIDEN NAME<br><i>Lylla Causey</i>   |   |
| 19. INFORMANT<br><i>Lillian Ford</i>   |                              | 20. ADDRESS<br><i>303 Rosette Ave. # 12</i>   |   |

|   |  |                                  |
|---|--|----------------------------------|
| I. CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) <i>Carcinoma of liver</i><br>DUE TO   |  |                                  |
| (B) <i>Myocardial damage due to atherosclerotic heart disease</i><br>DUE TO   |  |                                  |
| (C) <i>Marked anemia sec. to malignancy</i><br>DUE TO   |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><i>0</i>  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21c. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |
| 2. I hereby certify that I attended the deceased from <i>7/3</i> , 1953, to <i>7/26</i> , 1953, that I last saw the deceased alive on <i>7/26</i> , 1953, and that death occurred at <i>4:30 A.M.</i> , from the causes and on the date stated above. |  |   |  |   |  |
| 3a. SIGNATURE<br><i>Galeriana B. Castells</i>   |  | 23b. ADDRESS<br><i>Maryland gen. Hosp.</i>  |  | 23c. DATE SIGNED<br><i>7/26/53</i>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>RIAL</i>  |  | 24b. DATE<br><i>7-28-1953</i>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><i>PARKWOOD</i>                       |  |
| 24d. LOCATION (City, town, or county)<br><i>BALTO. Co.</i>  |  | 24e. (State)<br><i>MD.</i>  |  |   |  |
| 25. FUNERAL DIRECTOR<br><i>H. W. JENKINS &amp; SONS Co.</i>   |  | 25a. ADDRESS<br><i>4905 YORK RD.</i>  |  |   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 6795

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES A. HEARTLEY

2. DATE  
OF  
DEATH

7-25-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

419 S. BOND ST.

C. CITY OR TOWN

BALTO

3-01

D. STREET ADDRESS (If rural, give location)

419 S. BOND ST

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

9-19-1896

9. AGE (In years  
last birthday)

56

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR  
INDUSTRY

Ships

11. BIRTHPLACE (State or foreign country)

Beltsville Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Albert Heartley

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1st yr. yr.

16. SOCIAL  
SECURITY NO.

212-12-1571

17. INFORMANT

Box 178 Route 3  
Edward Heartley Fairfax Va.

18.

581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

FATTY INFILTRATION  
OF LIVER

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Congenital Absence of Rt Coronary

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. R. Fisher

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
7-26-5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

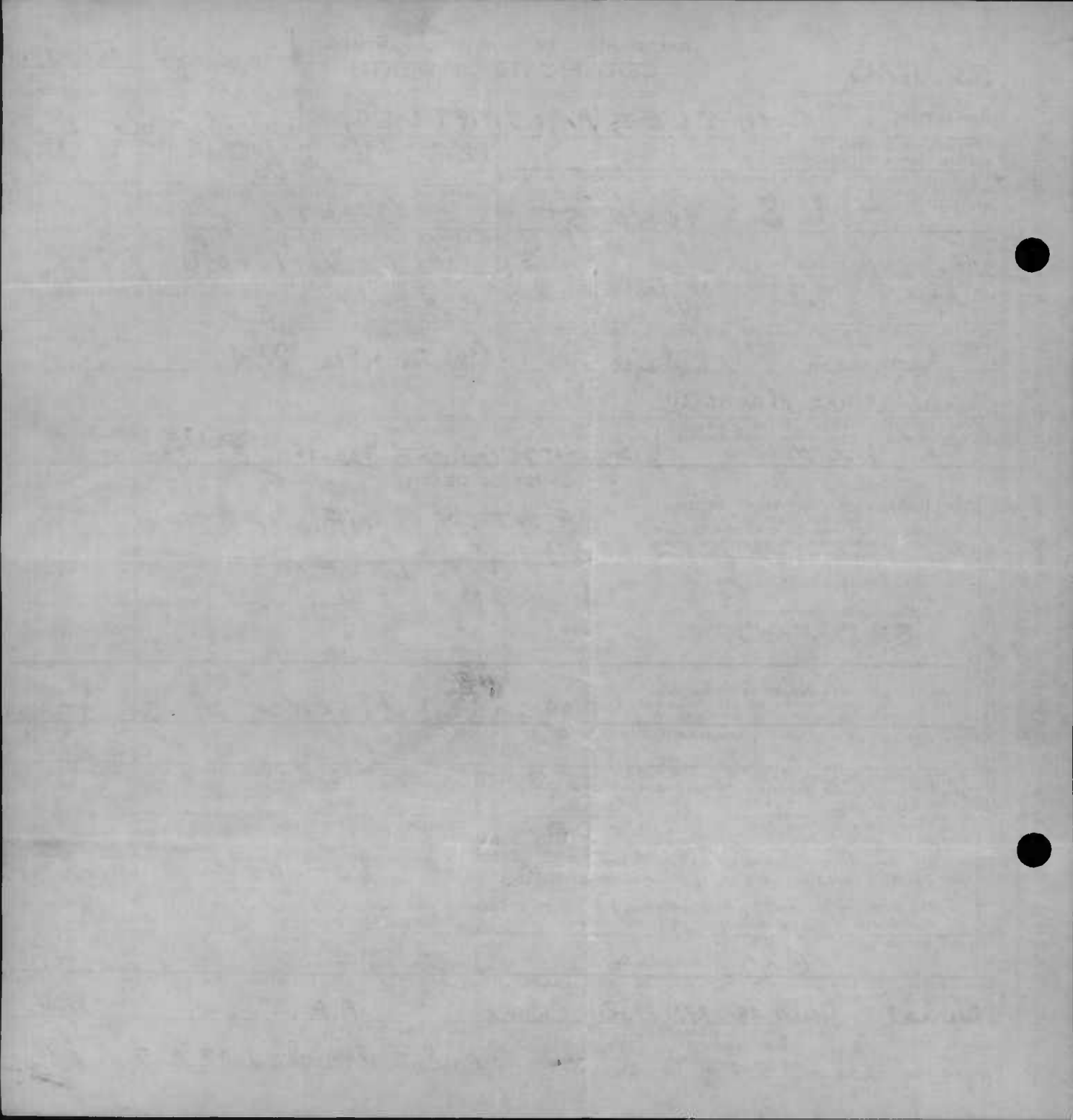
(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





53 6796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6796

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E. Jackson

2. DATE  
OF  
DEATH

7-25-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Baltimore, B. COUNTY 1

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONProvident Hospital  
Baltimore, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 18-03

D. STREET ADDRESS (If rural, give location)

1103 Booth Street

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

8-19-1894

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur Hopkins

14. MOTHER'S MAIDEN NAME

Eliza Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Charles Palmer 527 W. Mulberry St.

18. 760 x 1

CAUSE OF DEATH

Baltimore

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(A) Incompetence  
DUE TO Hypertensive Cardiovascular Disease

1 week

(B) Diabetic Arteriosclerotic Gangrene  
DUE TO of feet

4 months

(C) Diabetes mellitus

unknown

marked obesity

19A. DATE OF OPERATION

7-16-53

19B. MAJOR FINDINGS OF OPERATION

Diabetic Arteriosclerotic Gangrene of left Foot

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16-, 1953, to 7/25/, 1953, that I last saw the  
deceased alive on 7/24/, 1953, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

William E. L. Stewart

M. D.

23B. ADDRESS

Provident Hospital, Baltimore, Md.

23C. DATE SIGNED

7/25/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/30/53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Frederick Ave. B. D. St. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Metropolitan Funeral Home Inc.

1949 Edmundson Ave.

VS 150

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6797  
Registered No. 53 6797

53 6797  
BIRTH NO.

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>AARON</b>  |                                  | STEIN   |  | 2. DATE OF DEATH<br><b>July 27, 1953</b>                         |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>New Jersey</b><br>B. COUNTY |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2118 N. Pulaski St.</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Newark</b>                                    |  |  |
| c. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>21 Harding Place</b>   |  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>4-3</b>   |  | 9. AGE (in years last birthday) <b>43</b><br>If Under 1 Year: Months<br>Days<br>If Under 24 Hours: Hours<br>Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>merchant</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Toys</b>                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md</b> |  |
| 13. FATHER'S NAME<br><b>Abraham</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)       |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Jean Stein - Same</b>                        |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>470.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerosis of coronary arteries, xxx marked, with thrombotic occlusion of left coronary artery</b><br>(A) |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>(B) <b>Pulmonary Edema</b>   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)  |  |                                  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

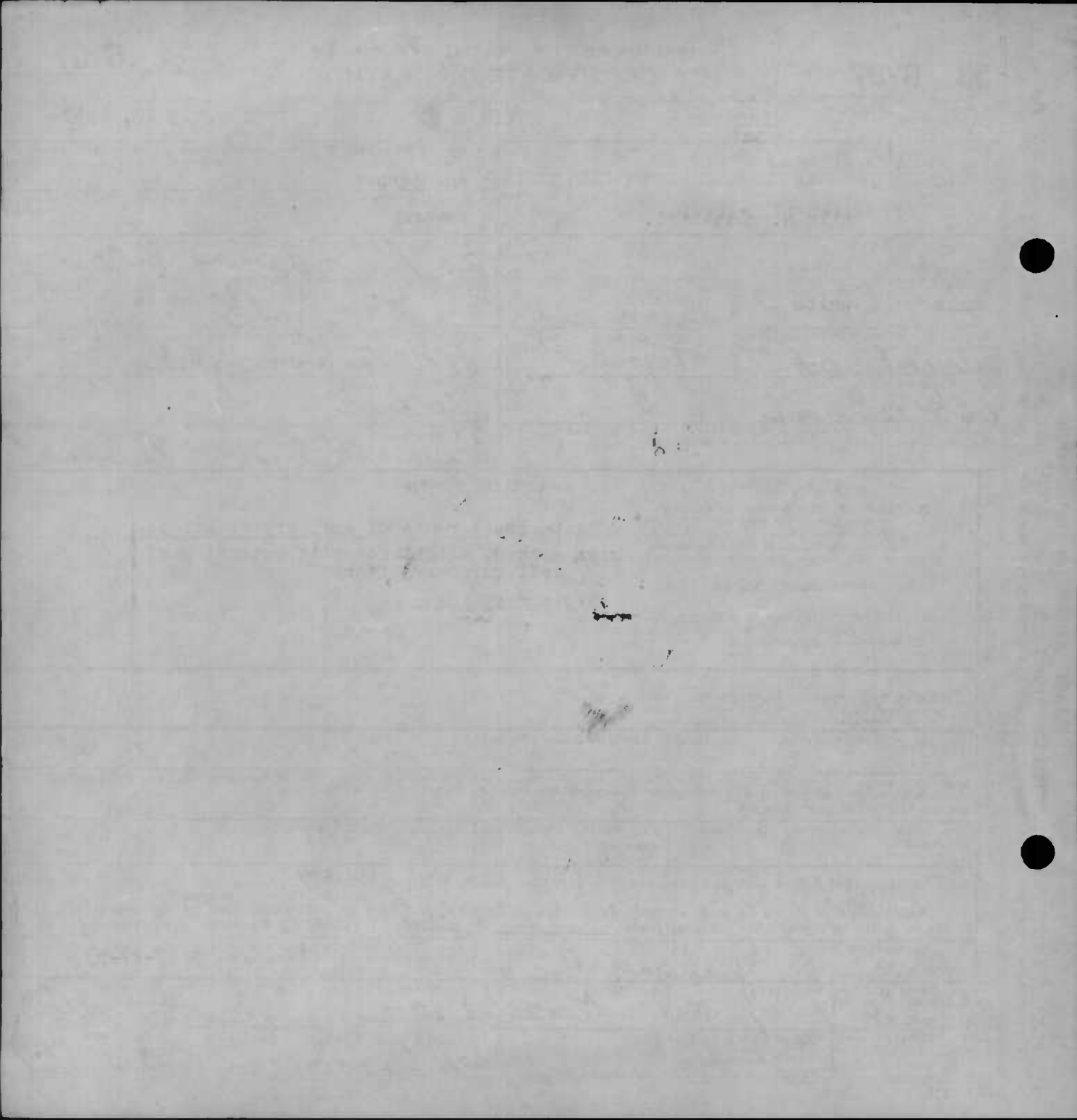
|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b>              |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>7-27-53</b>                         |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b> |  | 24B. DATE<br><b>7-27-53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>      |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 27 1953</b>     |  | REGISTRAR'S SIGNATURE<br><b>Thurston Williams</b>   |  | 25. FUNERAL DIRECTOR<br><b>Jack Lewis No 2100 Eutaw St</b> |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

29060



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6798

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED (Last, first, middle, or Print)<br><del>ANDRZEJ SZULC</del> ANDREW F. SCHULTZ   |  | 2. DATE OF DEATH<br>7/25/53  |  |
| PLACE OF DEATH: Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD. B. COUNTY Balto. |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>Sinner Hospital of Balto., Inc.  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE 26-36                        |  |
| D. STREET ADDRESS (If rural, give location)<br>3401 Toone St., Balto-24  |  | 8. DATE OF BIRTH<br>11-30-1893   |  |
| 9. AGE (In years, last birthday)<br>56   |  | 10. UNDER 1 Year Months: Days: Hours: Min.   |  |
| 11. BIRTHPLACE (State or foreign country)<br>EVERSON, Penna.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 14. MOTHER'S MAIDEN NAME<br>JOSEPHINE BOLOCEREK.   |  | 17. INFORMANT ADDRESS<br>JOSEPHINE F. SCHULTZ SAME   |  |
| 1. SEX<br>Male   |  | 6. COLOR OR RACE<br>White  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married   |  | 10. KIND OF BUSINESS OR INDUSTRY<br>SELF   |  |
| 13. FATHER'S NAME<br>JOSEPH SCHULTZ  |  | 16. SOCIAL SECURITY NO.<br>218-18-3232   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes WORLD WAR I  |  | 18. CAUSE OF DEATH<br>Interval between onset and death   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Antecedent causes<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | (A) Left ventricular strain Epulmonary edema<br>(B) posterior myocardial infarct<br>(C)                                |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |
| 9A. DATE OF OPERATION<br>0   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |
| 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7-24, 1953, to 7-25, 1953, that I last saw the deceased alive on 7-25, 1953, and that death occurred at 5:10 A.M., from the causes and on the date stated above.  |  |  |  |
| 23A. SIGNATURE<br>Norman L. Mulla  |  | 23B. ADDRESS<br>Sinner Hosp. 4 Balto. Int.   |  |
| 23C. DATE SIGNED<br>7/25/53  |  | 23D. ADDRESS<br>901 S. CONKLING ST. BALTO., MD.  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 24B. DATE<br>7-28-53   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY CEM.   |  | 24D. LOCATION (City, town, or county) (State)<br>MD.   |  |
| 25. FUNERAL DIRECTOR<br>Huntington Williams, Mortuary, 2906 M  |  | 25. FUNERAL DIRECTOR<br>901 S. CONKLING ST. BALTO., MD.  |  |

VS 150 27 1953





L-460

53 6799

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6799

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

Lawler, Norman Melbourne, Sr.

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:  
Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
LOCATION (If not in hospital or institution, give street address or location)

St. Joseph's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-31

Length of stay in Baltimore

32 years

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3816 Ferndale Avenue

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-23-1893

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Page checker

10B. KIND OF BUSINESS OR  
INDUSTRY

B. &amp; O. R. R.

11. BIRTHPLACE (State or foreign country)

Marshall Virginia

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Joseph Lawler

14. MOTHER'S MAIDEN NAME

Mary E. Royston

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

Yes WW I

16. SOCIAL  
SECURITY NO.

705-05-8433

17. INFORMANT

ADDRESS

Marie Barbara Lawler

8.

CAUSE OF DEATH 3816 Ferndale Ave

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Dissecting aneurysm of the thoracic

DUE TO

ANTECEDENT CAUSES

(B) aorta

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Duodenal ulcer

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1953 to July 26, 1953 that I last saw the  
deceased alive on July 26, 1953, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Nathanial P. Santiago

M. D.

1100 N. Caroline Street

July 26, 1953

BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-29-1953

Arlington National

Arlington Virginia

E RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

27-1053 Huntington Ave. Baltimore, Md.

E. S. S. WORTH Armacost  
4600 LIBERTY HEIGHTS AVENUE

VS 150

731 50

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Death: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Signature of Physician: \_\_\_\_\_

9. Signature of Registrar: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_

11. Signature of Medical Examiner: \_\_\_\_\_

12. Signature of Funeral Home: \_\_\_\_\_

13. Signature of Family: \_\_\_\_\_

14. Signature of Other: \_\_\_\_\_

15. Signature of Other: \_\_\_\_\_

16. Signature of Other: \_\_\_\_\_

17. Signature of Other: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

25. Signature of Other: \_\_\_\_\_

26. Signature of Other: \_\_\_\_\_

27. Signature of Other: \_\_\_\_\_

28. Signature of Other: \_\_\_\_\_

29. Signature of Other: \_\_\_\_\_

30. Signature of Other: \_\_\_\_\_

31. Signature of Other: \_\_\_\_\_

32. Signature of Other: \_\_\_\_\_

33. Signature of Other: \_\_\_\_\_

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41. Signature of Other: \_\_\_\_\_

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51. Signature of Other: \_\_\_\_\_

52. Signature of Other: \_\_\_\_\_

53. Signature of Other: \_\_\_\_\_

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89. Signature of Other: \_\_\_\_\_

90. Signature of Other: \_\_\_\_\_

91. Signature of Other: \_\_\_\_\_

92. Signature of Other: \_\_\_\_\_

93. Signature of Other: \_\_\_\_\_

94. Signature of Other: \_\_\_\_\_

95. Signature of Other: \_\_\_\_\_

96. Signature of Other: \_\_\_\_\_

97. Signature of Other: \_\_\_\_\_

98. Signature of Other: \_\_\_\_\_

99. Signature of Other: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

1-532  
53 6800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6800  
Registered No.

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><b>Lda B. Montague</b>  |                                    | 2. DATE OF DEATH<br><b>7-25-53</b>   |   |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland <b>523 W Biddle</b><br>(If not in hospital or institution, give street address or location)   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>00</b>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 17-01</b>                         |   |
| 6. LENGTH OF stay in Baltimore <b>23 yrs</b>   |                                    | D. STREET ADDRESS (If rural, give location)<br><b>523 W. Biddle ST.</b>  |   |
| 7. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>12-25-1910</b>         |
| 9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>house wife</b>  |                                    | 10. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>43</b>  |
| 11. FATHER'S NAME<br><b>John Shanley</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Norfolk Va</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Ella Harried Va</b>   | 17. INFORMANT<br><b>Elvis Montague</b>        |
| 16. SOCIAL SECURITY NO.  |                                    | ADDRESS<br><b>523 W. Biddle St.</b>  |   |
| 8. <b>331X I</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b><br>DUE TO<br><b>Hypertension</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b> |                                    |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                    |  |   |
| 9A. DATE OF OPERATION<br><b>0</b>  |                                    | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                    |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                         |   |
| 21F. HOW DID INJURY OCCUR?   |                                    |  |   |
| 22. I hereby certify that I attended the deceased from <b>7/24/53</b> , 19 <b>53</b> , to <b>7/25/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/24/53</b> , 19 <b>53</b> , and that death occurred at <b>2:00 p.m.</b> , from the causes and on the date stated above.  |                                    |  |   |
| 23A. SIGNATURE<br><b>William Garner M.D.</b>   |                                    | 23B. ADDRESS<br><b>753 G St</b>  |   |
| 23C. DATE SIGNED<br><b>7/27/53</b>   |                                    |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 24B. DATE<br><b>7-30-53</b>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Wm. A. Jackson</b>  |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |   |
| 25. FUNERAL DIRECTOR<br><b>Wm. A. Jackson</b>  |                                    | ADDRESS<br><b>916 penma</b>  |   |

TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT, WASHINGTON, D. C.

FROM THE CHIEF OF THE DISTRICT OFFICE, [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

F-462  
MAF-172508

53 6801

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6801  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Flowers

2. DATE  
OF  
DEATH 7-24-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)31  
Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

16-03

D. STREET ADDRESS (If rural, give location)

600 Etting St. → 600 B... →

c. Length of stay in Baltimore

30 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Jan. 3, 1907

9. AGE (in years,  
last birthday)

45

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Sam Flowers

14. MOTHER'S MAIDEN NAME

Angie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 002X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Tuberculosis, Far Advanced 10 mos.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20, 1953, to 7-24, 1953, that I last saw the  
deceased alive on 7-24, 1953, and that death occurred at 3 P m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Williams

23B. ADDRESS

M. D.

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

7-24-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-29-53

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Balto. City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. Jackson 916 Penna.  
ave.

JUL 27 1953

628 <sup>14</sup> Prince from The Russian file

B.C.H.D.

7-28-53

20



| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |   | 53 6802  |  |
|--|--|---|---|--|--|
| CERTIFICATE OF DEATH   |  |   |   | Registered No.   |  |
| 1. NAME OF DECEASED (or Print)<br><b>BABY GIRL VITILIO</b>   |  |   | 2. DATE OF DEATH<br><b>July 26, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>MARYLAND</b><br>B. COUNTY |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>PITAL OR<br>STITUTION<br><b>MERCY HOSPITAL</b>   |  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b><br><b>27-03</b>                  |  |  |
| 6. LENGTH OF stay in Baltimore<br><b>LIFE</b>  |  |   | D. STREET ADDRESS (If rural, give location)<br><b>5111 PLYMOUTH ROAD</b>  |  |  |
| 7. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b>                     |  |
| 8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>INFANT -</b>  |  | 10a. KIND OF BUSINESS OR INDUSTRY   |   | 8. DATE OF BIRTH<br><b>JULY 26, 1953</b>   |  |
| 9. FATHER'S NAME<br><b>JOHN JOSEPH VITILIO</b>   |  | 10b. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 9. AGE (In years last birthday)<br><b>0 5</b>  |  |
| 10. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>PREMATURITY</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | 14. MOTHER'S MAIDEN NAME<br><b>PATRICIA VIRGINIA Di GALLO</b>   |   | 17. INFORMANT<br><b>MOTHER</b><br>ADDRESS<br><b>5111 PLYMOUTH AVE.</b>               |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>NONE</b>   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NONE</b>  |   | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>-</b> |  |
| 21d. TIME (Month) (Day) (Year) (Hour) (Minute)<br><b>7 55 P</b>  |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |  |
| 2. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>July 26, 1953</b> , and that death occurred at <b>6:55 P m.</b> , from the causes and on the date stated above.  |  |   |   |  |  |
| 3a. SIGNATURE<br><b>Charles H. Doeller</b>   |  | 23b. ADDRESS<br><b>MERCY HOSPITAL</b>   |   | 23c. DATE SIGNED<br><b>JULY 26, 1953</b>   |  |
| 24a. BURIAL, CREMA-REMOVAL (Specify)<br><b>URIAL</b>   |  | 24b. DATE<br><b>JULY 27, 1953</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM</b>                       |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>4430 BELAIR RD MD</b>  |  | 25. FUNERAL DIRECTOR<br><b>Deffel Bros.</b>   |   | ADDRESS<br><b>1800 E LOMBARD ST</b>  |  |

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

WEIGHT

HEIGHT

TEMPERATURE

EDUCATION

RELIGION

MARRIAGE

DATE OF MARRIAGE

CAUSE OF DEATH

INFORMANT

DATE OF REPORT

REPORTED BY

DATE OF REPORT

1

2

3

4

5

6

7

8

9

10

626

53 6803

53 6803

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No.

H NO.

NAME OF DECEASED

(Kor) Catherine Mary Traysen

2. DATE  
OF  
DEATH

26 July 53

PLACE OF DEATH:

Baltimore City, Maryland Balto Md

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

(before admission)

5. ALL NAME OF (If not in hospital or institution, give street address or location)

44 Union Memorial Hosp Balto

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

104 Walnut Ave

Length of stay in Baltimore

life

Yrs  
Mos.  
Days

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

27 Feb 1878

9. AGE (In years  
last birthday)

82

If Under 1 Year  
Months Days Hours Min.10. USUAL OCCUPATION (Give kind of  
during most of working life, even if retired)

HOUSE WORK

10b. KIND OF BUSINESS OR  
INDUSTRY

- AT HOME

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

Philip Baddinger

14. MOTHER'S MAIDEN NAME

Theresa Hergel

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Self

ADDRESS

St.

B. 420.1 and E 903.0 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary artery occlusion many yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis

DUE TO

(C)

CERTIFICATION APPROVED BY

Joseph A. Jakubowski

CHIEF OR ASST. MEDICAL EXAMINER.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Fractured hip left

9A. DATE OF OPERATION

15 July 53

19b. MAJOR FINDINGS OF OPERATION

Fractured hip H. intertrochanteric

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., In or  
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID  
INJURY OCCUR?

home 104 Walnut Ave, Balto

1D. TIME (Month) (Day) (Year) (Hour)

July 53

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

slipped on rug

22. I hereby certify that I attended the deceased from 8 July 1953, to 26 July 1953, that I last saw the  
deceased alive on 26 July 1953, and that death occurred at 3:19 a.m., from the causes and on the date stated above.

3A. SIGNATURE

R.B. Caraway Jr

M. D.

23b. ADDRESS

% Union Memorial Hosp

23c. DATE SIGNED

26 July 53

BURIAL, CREMA-  
REMOVAL (Specify)

24b. DATE

JULY 29 1953

24c. NAME OF CEMETERY OR CREMATORY

HOLY RED EEMER CEM

24d. LOCATION (City, town, or county) (State)

4430 BELAIR RD MD.

E RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

J. J. Williams, M.D.

25. FUNERAL DIRECTOR

Duffel Bros

ADDRESS

7110 BELAIR RD.

VS 150

N-820.0

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

[The body of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or letter, possibly containing a subject line, a salutation, and several paragraphs of descriptive text. There are also some small, dark marks and artifacts visible on the page, particularly in the lower left corner.]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6804  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES CAMPHOR

2. DATE  
OF  
DEATH

7/26/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto.

16-02

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1/13/09

9. AGE (in years,  
last birthday)

44

10. Under 1 Year Months: Days  
11. Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR  
INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Balto.

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thos. Camphor

14. MOTHER'S MAIDEN NAME

Rebecca Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Beatrice Camphor 1120 N. Calhoun St.

18.

E 981X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

GUNSHOT WOUND OF  
CHEST

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

STREET

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1309 Edmondson AVE

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

7 26 53

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during Altercation

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

B. H. Ash M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

7-26-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

7/30/53

24C. NAME OF CEMETERY OR CREMATORY

MTAUBURN

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Geo. G. Nelson 1303 Presstman St.

ADDRESS

VS 151

N-862.4

685-30

Geo. G. Nelson





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6805  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JESSIE MAY HURST

2. DATE  
OF  
DEATH

7/25/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto.

20-02

D. STREET ADDRESS (If rural, give location)

2405 Lauretta Ave.

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

9/24/04

9. AGE (In years  
last birthday)

48

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

H. Wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Virginia Griggs

14. MOTHER'S MAIDEN NAME

William Griggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Bernard Hurst 2405 Lauretta Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Carcinomatosis due to  
DUE TO Carcinoma of Ovary

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER... ☒  
ASSISTANT MEDICAL EXAMINER... ☐  
MEDICAL INVESTIGATOR... ☐

23C. DATE SIGNED

7-26-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/29/53

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk, Inc.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

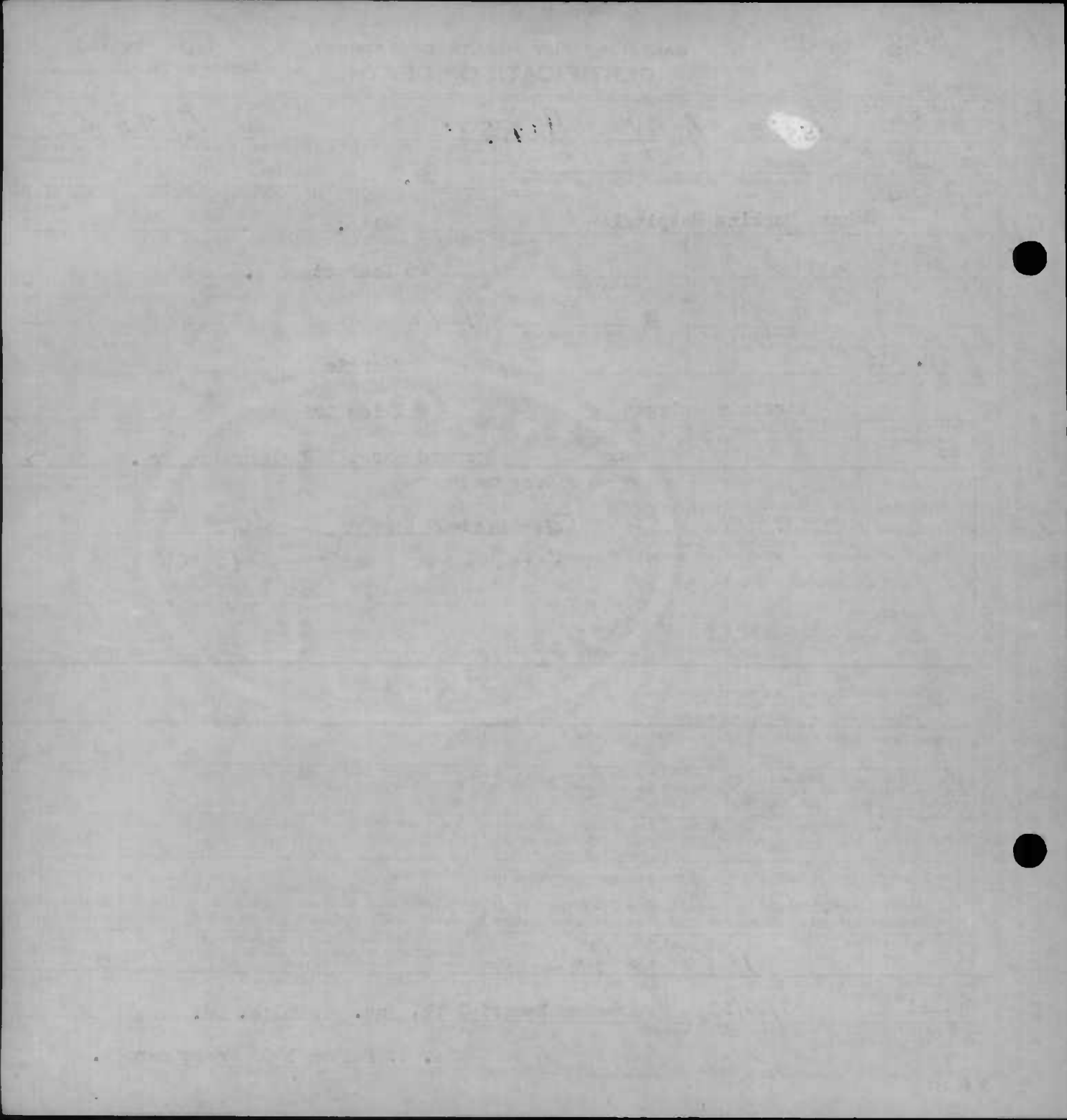
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presstman St.

Geo. H. Kelson



H-610  
53 6806BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6806  
Registered No.

|  |                       |   |                                   |
|--|-----------------------|---|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)   |                       | 2. DATE OF DEATH  |                                   |
| Susan Jordan Harvey  |                       | 7-27-53   |                                   |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md<br>B. COUNTY   |                                   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>1249 N. Broadway  |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 8-07                      |                                   |
| 6. LENGTH OF STAY IN BALTIMORE<br>Length of stay in Baltimore  |                       | D. STREET ADDRESS (If rural, give location)<br>1249 N. Broadway   |                                   |
| 7. SEX<br>F  | 8. COLOR OR RACE<br>C | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>m  | 10. DATE OF BIRTH<br>Oct. 31/1909 |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br>Housewife   |                       | 12. AGE (In years last birthday)<br>43  |                                   |
| 13. FATHER'S NAME<br>Elijah Howard   |                       | 14. MOTHER'S MAIDEN NAME<br>Sarah Canall  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)   |                       | 16. SOCIAL SECURITY NO.   |                                   |
| 17. INFORMANT<br>Eugene Harvey - 1249 Broadway   |                       | 18. ADDRESS   |                                   |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive Cardio-Vascular<br>Renal Disease. |                       | 20. INTERVAL BETWEEN ONSET AND DEATH<br>4 wks.<br>4 mos.  |                                   |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                       | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                   |
| 23. DATE OF OPERATION  |                       | 24. MAJOR FINDINGS OF OPERATION   |                                   |
| 25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                       | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |                                   |
| 27. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                       | 28. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |                                   |
| 29. I hereby certify that I attended the deceased from 7/20, 1953, to 7/27, 1953, that I last saw the deceased alive on 7/26, 1953, and that death occurred at 8:30 A. M., from the causes and on the date stated above.                             |                       | 30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                   |
| 31. SIGNATURE<br>J. Preston Hunt   |                       | 32. ADDRESS<br>601 N. Carrollton  |                                   |
| 33. DATE<br>7-29-53  |                       | 34. DATE SIGNED<br>7/27/53  |                                   |
| 35. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary   |                       | 36. LOCATION (City, town, or county) (State)<br>A. A. C. Md   |                                   |
| 37. DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 27 1953  |                       | 38. REGISTRAR'S SIGNATURE<br>Samuel W. Sullivan Jr  |                                   |
| 39. VLS 150  |                       | 40. FUNERAL DIRECTOR<br>Huntington Williams, M.D. 1011 N. Arlington Ave   |                                   |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ESTHER JONES

2. DATE  
OF  
DEATH

July 23, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MarylandB. FULL NAME OF (not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE38 University HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

821 W. Fairmount Ave.

c. Length of stay in Baltimore

LifeYrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Dec.-18-1904

9. AGE (In years last birthday)

48If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William Coby

14. MOTHER'S MAIDEN NAME

Sarah Jefferson15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Charles Jones 821 W. Fairmount Ave

18.

156.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the liver

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jackson

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

July 23, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/28/1953

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md.

(State)

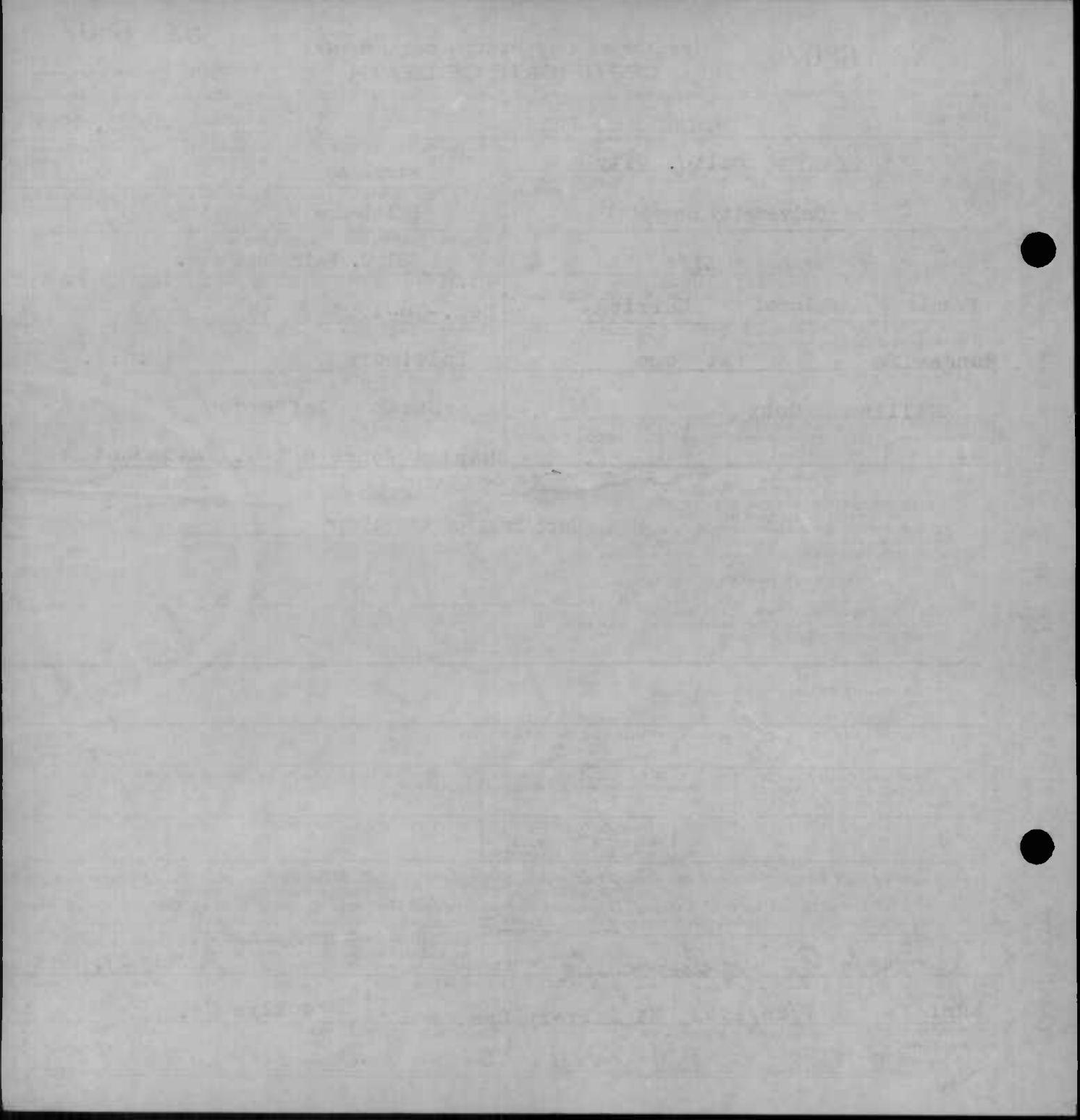
DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

REG. NO. 27153Huntington Williams, Jr.Chas. O. Wilson1000 Beauty





C-635  
53 6808BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6808  
Registered No.

BIRTH NO.

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Gannie Cureton</u>  |                                 | 2. DATE OF DEATH <u>July 24, 1953</u>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Balto. City</u>  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)<br>A. STATE <u>Md.</u><br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>7-04</u>               |   |
| c. Length of stay in Baltimore <u>18 Yrs.</u><br>Yrs. Mos. Days   |                                 | D. STREET ADDRESS (If rural, give location)<br><u>928 N. Dunham St.</u>  |   |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  | B. DATE OF BIRTH <u>Sept-2-1897</u>       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Watchman</u>                  |                                 | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Public Bldg.</u>   | 9. AGE (In years last birthday) <u>55</u> |
| 13. FATHER'S NAME<br><u>Rubbin Cureton</u>  |                                 | 11. BIRTHPLACE (State or foreign country)<br><u>Sharlott N.C.</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>           |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 16. SOCIAL SECURITY NO.   |                                 | 14. MOTHER'S MAIDEN NAME<br><u>Curry ?</u>   |   |
| 17. INFORMANT<br><u>JOHNS HOPKINS HOSPITAL</u>  |                                 | ADDRESS  |   |

18. 023X I CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) Primary Cause Unknown  
DUE TO

## ANTECEDENT CAUSES

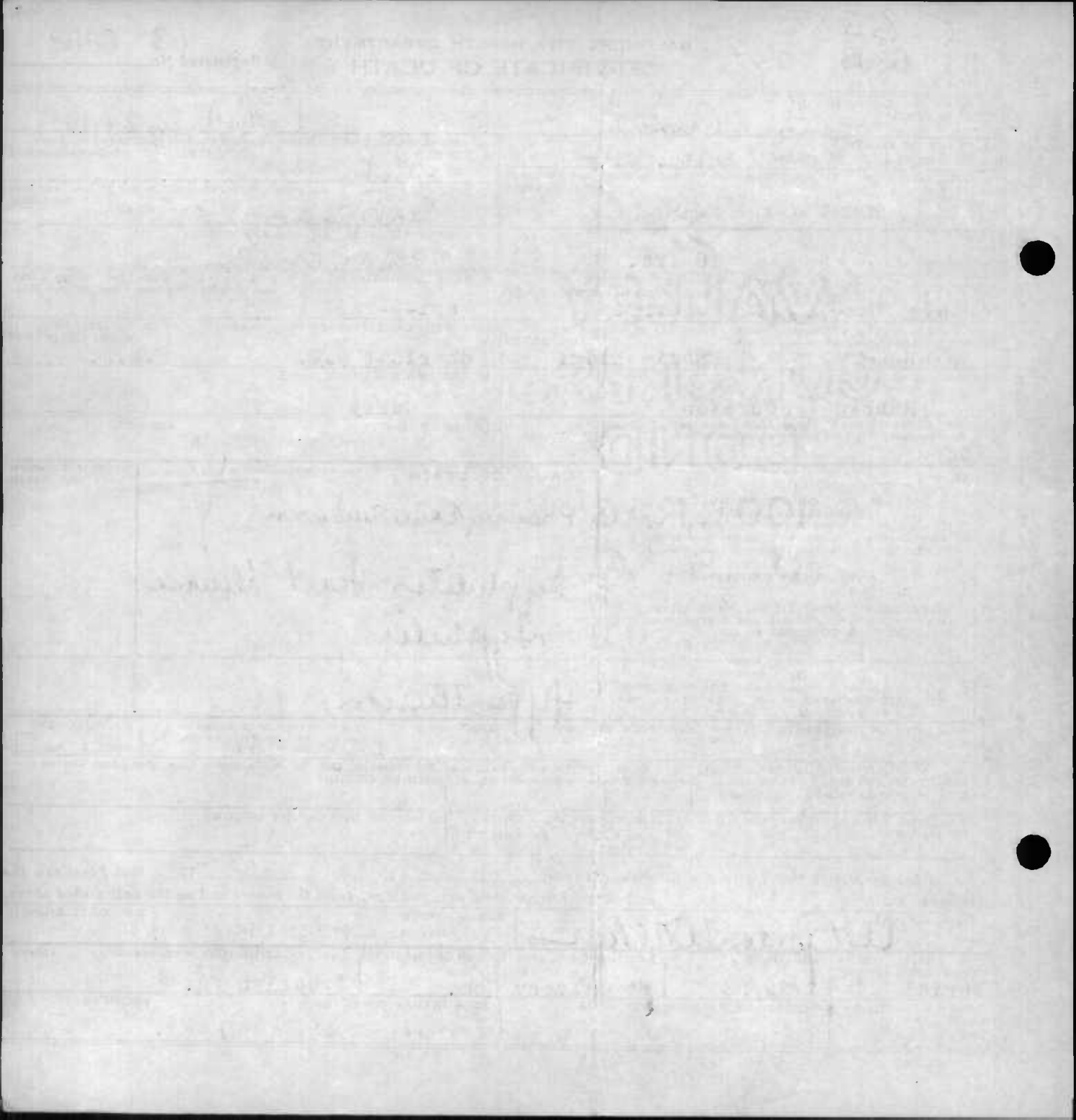
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Syphilis Heart Disease  
DUE TO(C) SyphilisII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Hypertension

|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION<br><u>0</u>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 2:00 A. M., from the causes and on the date stated above.23A. SIGNATURE W. Gordon Walker 23B. ADDRESS JOHNS HOPKINS HOSPITAL 23C. DATE SIGNED

|  |                             |  |  |
|--|-----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 24B. DATE<br><u>7/29/53</u> | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt Calvary Cem.</u> | 24D. LOCATION (City, town, or county) (State)<br><u>Brooklyn Md.</u> |
| DATE RECEIVED BY LOCAL REGISTRAR                           | REGISTRAR'S SIGNATURE       | 25. FUNERAL DIRECTOR<br><u>Elroy O. Wilson, 1000 South</u>   | ADDRESS  |



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6809  
Registered No.

BIRTH NO.

|  |                              |   |   |   |   |
|--|------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>THOMAS C. SIFFRIN</b>   |                              |   | 2. DATE OF DEATH<br><b>7/26/53</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>4004 Walrad Avenue</b>  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>00</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore 20-08</b>                   |   |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>4004 Walrad Avenue</b>  |   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b> | 8. DATE OF BIRTH<br><b>8/29/77</b>  | 9. AGE (In years last birthday)<br><b>75</b>                  | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Inspector</b>              |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Locke Ins. Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b> |   |
| 13. FATHER'S NAME<br><b>Joseph</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Mullica</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>         |                              | 16. SOCIAL SECURITY NO.                                     |   | 17. INFORMANT ADDRESS<br><b>Family - Same</b>                 |   |

|  |   |  |   |
|--|---|--|---|
| 18. <b>470.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anterior Ischemic Heart Disease</b><br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH |   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>(C)   |   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>① Bleeding duodenal ulcer.<br/>② Benign Prostatic Hypertrophy</b>   |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?     |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7/26/1953</b> , to <b>7/26/1953</b> , that I last saw the deceased alive on <b>7/25/53</b> , 19____ and that death occurred at <b>10 p.m.</b> , from the causes and on the date stated above.  |   |  |   |
| 23A. SIGNATURE<br><b>N. P. Friedman</b><br>M. D.   |   | 23B. ADDRESS<br><b>1319 Lyster St.</b>                                       | 23C. DATE SIGNED<br><b>7/27/53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>  | 24B. DATE<br><b>7/29/53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>                     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>                   |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>Huntington Wallis, M.D.</b>   | 25. FUNERAL DIRECTOR ADDRESS<br><b>James L. McCully - 130 E. Fort Avenue</b> |   |

JUL 27 1953

U.S. A  
1000000  
BOND  
COMBES  
VALLEY

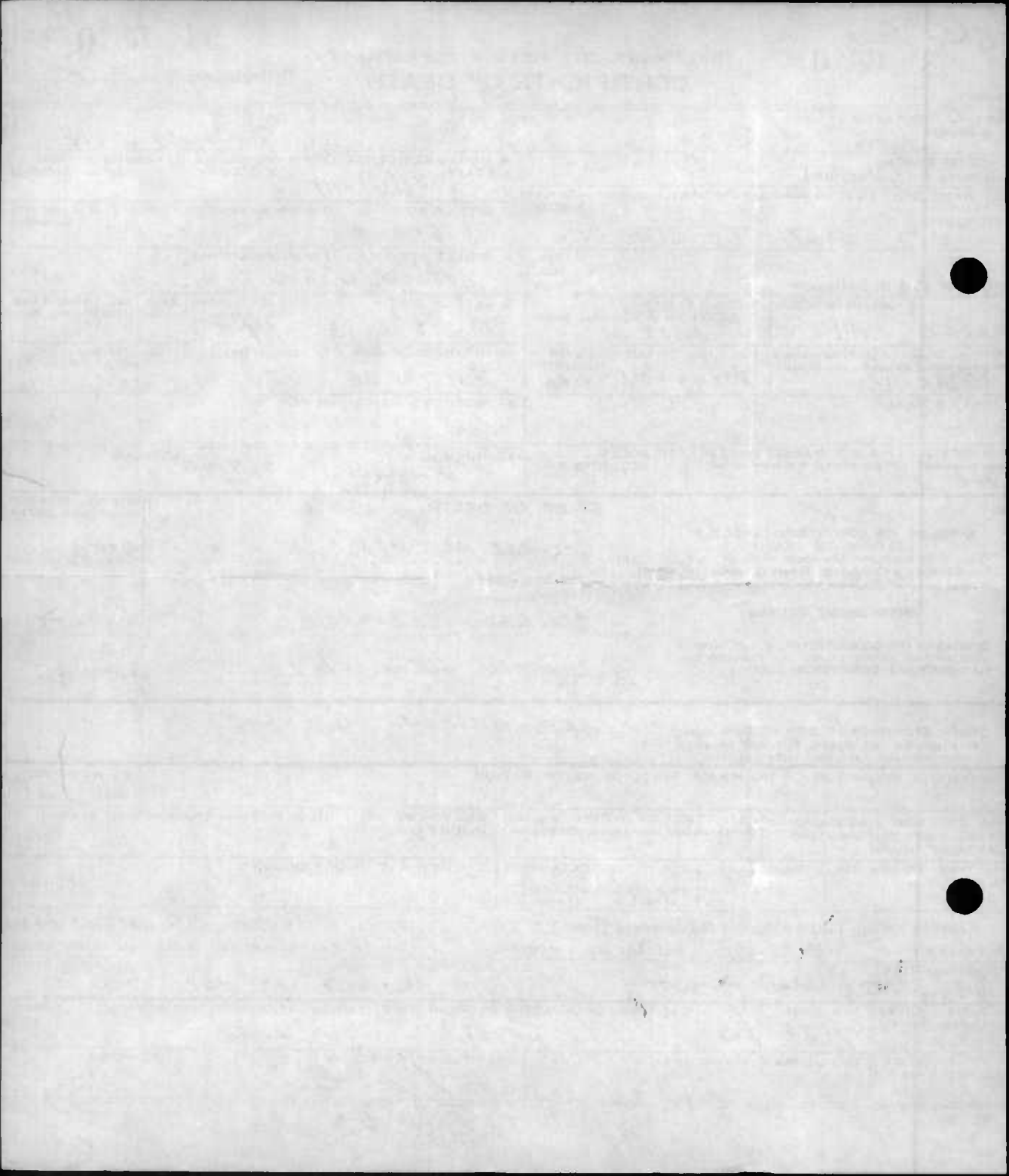
265-  
53 6810

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6810

Registered No. \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED (Last, first, middle, or Print)<br><b>JOHN Mc CORMICK</b>  |  | 2. DATE OF DEATH<br><b>July 24, 1953</b>   |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY _____                                       |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>SOUTH BALTIMORE GEN. HOSP</b>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b>   |  |
| 6. COLOR OR RACE<br><b>WHITE</b>   |  | D. STREET ADDRESS (If rural, give location)<br><b>3750 ST. MARGARET ST. BALTO. 25</b>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>  |  | 8. DATE OF BIRTH<br><b>Dec. 28, 1893</b>   |  |
| 8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><b>MECHANIC</b>  |  | 9. AGE (in years last birthday)<br><b>59</b>   |  |
| 9. FATHER'S NAME<br><b>?</b>   |  | 10. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  |
| 10. KIND OF BUSINESS OR INDUSTRY<br><b>PAVING CORP.</b>  |  | 11. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. SOCIAL SECURITY NO.<br><b>?</b>  |  | 12. MOTHER'S MAIDEN NAME<br><b>?</b>   |  |
| 12. HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No.</b>  |  | 13. INFORMANT<br><b>Family - Same</b>  |  |
| 13. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCTION</b>                               |  | 14. INTERVAL BETWEEN ONSET AND DEATH<br><b>1949 to 1953</b>  |  |
| 14. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>CORONARY THROMBOSIS</b>   |  | 15. DUE TO<br><b>CORONARY ARTERIO SCLEROSIS</b>  |  |
| 15. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>ARTERIOSCLEROSIS, GENERAL</b>  |  |  |  |
| 16. DATE OF OPERATION<br><b>0</b>  |  | 17. MAJOR FINDINGS OF OPERATION  |  |
| 18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |  | 19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b> |  |
| 20. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></b>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>July 18, 1953</b> , to <b>July 24, 1953</b> , that I last saw the deceased alive on <b>July 24, 1953</b> , and that death occurred at <b>11:00 pm.</b> , from the causes and on the date stated above. |  |  |  |
| 23A. SIGNATURE<br><b>Donald Benito Jimenez</b>   |  | 23B. ADDRESS<br><b>SOUTH BALTIMORE GEN. HOSP.</b>  |  |
| 23C. DATE SIGNED<br><b>7-24-53</b>   |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B.</b>   |  | 24B. DATE<br><b>7-28-53</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Abby Cross</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto.</b>   |  |
| 25. RECEIVED BY AL REGISTRAR<br><b>271153</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |  |
| 26. FUNERAL DIRECTOR<br><b>55424130 E. To J. A. S.</b>   |  | 26. ADDRESS  |  |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6811  
Registered No.

BIRTH NO.

|  |                              |  |                                      |
|--|------------------------------|--|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM CONLEY</b>   |                              | 2. DATE OF DEATH<br><b>JULY 25, 1953</b>   |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY |                                      |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>FRANKLIN SQUARE HOSPITAL</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 24-02</b>                 |                                      |
| D. STREET ADDRESS (If rural, give location)<br><b>1445 RIDGESIDE AVE</b>   |                              | E. LENGTH OF STAY IN BALTIMORE<br><b>36</b>  |                                      |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>  | 8. DATE OF BIRTH<br><b>8-27-1876</b> |
| 9. AGE (In years last birthday)<br><b>76</b>   |                              | 10. UNDER 1 YEAR<br>Months: Days   | 11. UNDER 24 HOURS<br>Hours: Min.    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FISHERMAN</b>                |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self.</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Boston, Mass</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?   |                                      |
| 13. FATHER'S NAME<br><b>Bartholomew</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes Sp. Am.</b> |                              | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT<br><b>Family Name</b>  |                              | ADDRESS  |                                      |

|  |                |                                  |
|--|----------------|----------------------------------|
| 18. <b>161X</b>  | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) CARCINOMA OF LARYNX</b> |                |                                  |
| DUE TO   |                |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) MARKED DEHYDRATION</b>  |                |                                  |
| DUE TO   |                |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C) UREMIA</b>   |                |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>7-23-53</b> , 19 <b>53</b> , to <b>7-25-53</b> 19 <b>53</b> , that I last saw the deceased alive on <b>7-25</b> , 19 <b>53</b> , and that death occurred at <b>4:40 pm.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>William L. Wilson</b>  |  | 23B. ADDRESS<br><b>120 E. FORT AVE.</b>   |  | 23C. DATE SIGNED<br><b>Jul 25 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>15</b>  |  | 24B. DATE<br><b>7-28-53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's</b>                            |  |
| 24D. LOCATION (City, town, or county)<br><b>BALTIMORE</b>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>Huntington Williams, M.D.</b>                                 |  | 24F. REGISTRAR'S SIGNATURE<br><b>Wm. L. Wilson</b>                                  |  |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 28 1953</b>   |  | 24H. FUNERAL DIRECTOR<br><b>Wm. L. Wilson</b>   |  | 24I. ADDRESS<br><b>120 E. FORT AVE.</b>   |  |

1940

CERTIFICATE OF DEATH



5-362  
53 6812

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6812  
Registered No.

H. NO.

NAME OF DECEASED  
or Print)

STRICKLER, William B

2. DATE  
OF  
DEATH

7/26/53

PLACE OF DEATH:

Baltimore City, Maryland

1. FULL NAME OF (If not in hospital or institution, give street address or location)

MARYLAND GENERAL HOSPITAL

Length of stay in Baltimore

77

Yrs.  
Mos.  
Days

6. COLOR OR RACE

M W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

COND. - B.O.R.C.

FATHER'S NAME

WILLIAM STRICKLER

9. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

-

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
MD

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

25-04

D. STREET ADDRESS (If rural, give location)

210 WASHBURN AVE

5. DATE OF BIRTH

JUNE 12 1876

9. AGE (In years last birthday)

77

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

CLARA BOSLEY

17. INFORMANT

WIFE & CHART

ADDRESS

SAME

CAUSE OF DEATH

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

CARCINOMA (MIXED) RT. PAROTID

INTERVAL BETWEEN ONSET AND DEATH

6 M +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

E C.N.S. EXTENSION

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

18A. DATE OF OPERATION

18B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

22A. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22B. IN

m.

WHILE AT WORK ☒

NOT WHILE AT WORK ☐

I hereby certify that I attended the deceased from 6/21, 1953 to 7/26, 1953, that I last saw the deceased alive on 7/25, 1953, and that death occurred at 7:19 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John A. Withers

M.D. Md. General Hosp.

7/26/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

25B. DATE

25C. NAME OF CEMETERY OR CREMATORY

25D. LOCATION (City, town, or county)

25E. ADDRESS

25F. DATE

25G. NAME OF CEMETERY OR CREMATORY

25H. LOCATION (City, town, or county)

25I. ADDRESS

25J. DATE

25K. NAME OF CEMETERY OR CREMATORY

25L. LOCATION (City, town, or county)

25M. ADDRESS

25N. DATE

25O. NAME OF CEMETERY OR CREMATORY

25P. LOCATION (City, town, or county)

25Q. ADDRESS

25R. DATE

25S. NAME OF CEMETERY OR CREMATORY

25T. LOCATION (City, town, or county)

25U. ADDRESS

25V. DATE

25W. NAME OF CEMETERY OR CREMATORY

25X. LOCATION (City, town, or county)

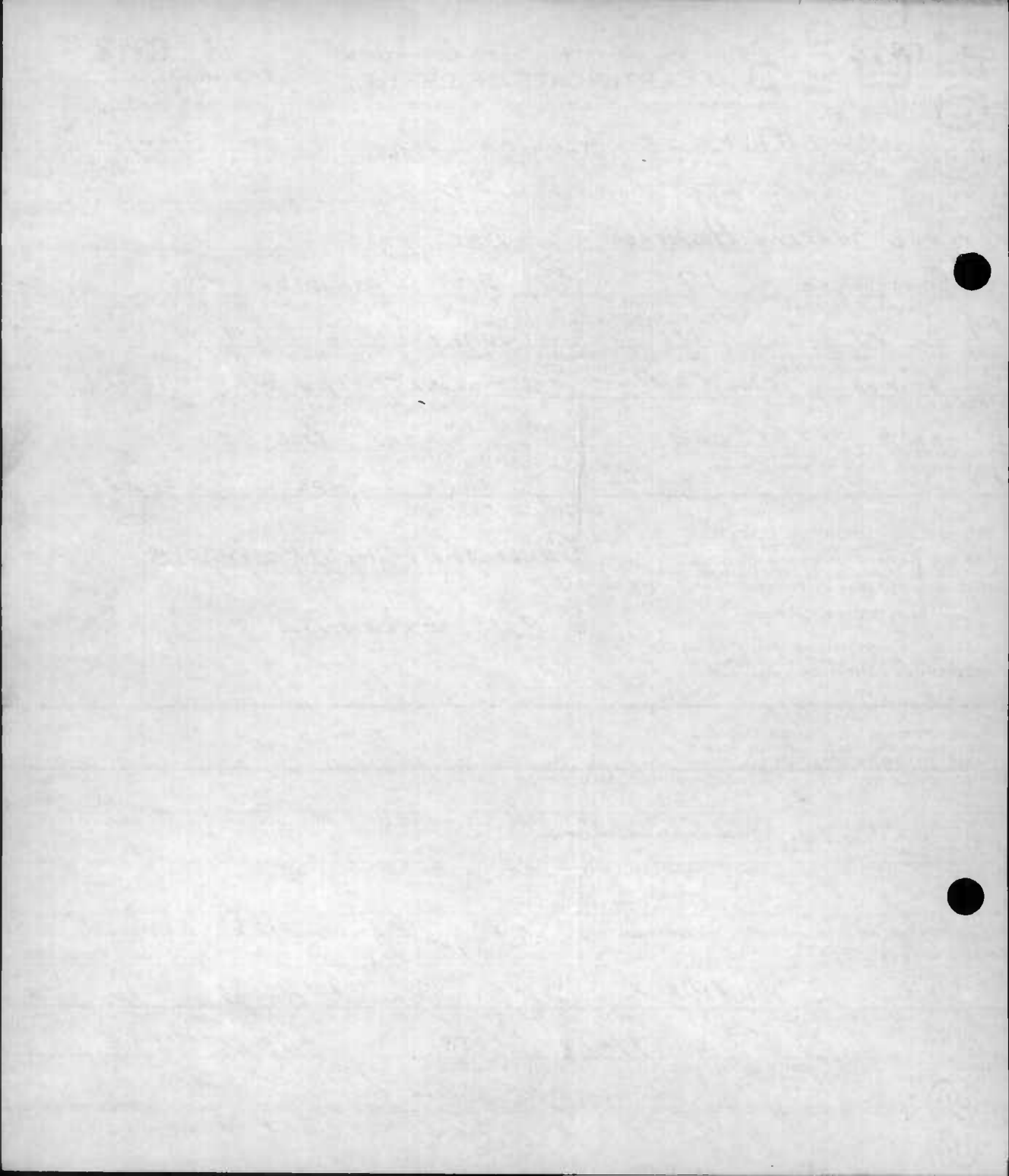
25Y. ADDRESS

25Z. DATE

25AA. NAME OF CEMETERY OR CREMATORY

25AB. LOCATION (City, town, or county)

25AC. ADDRESS



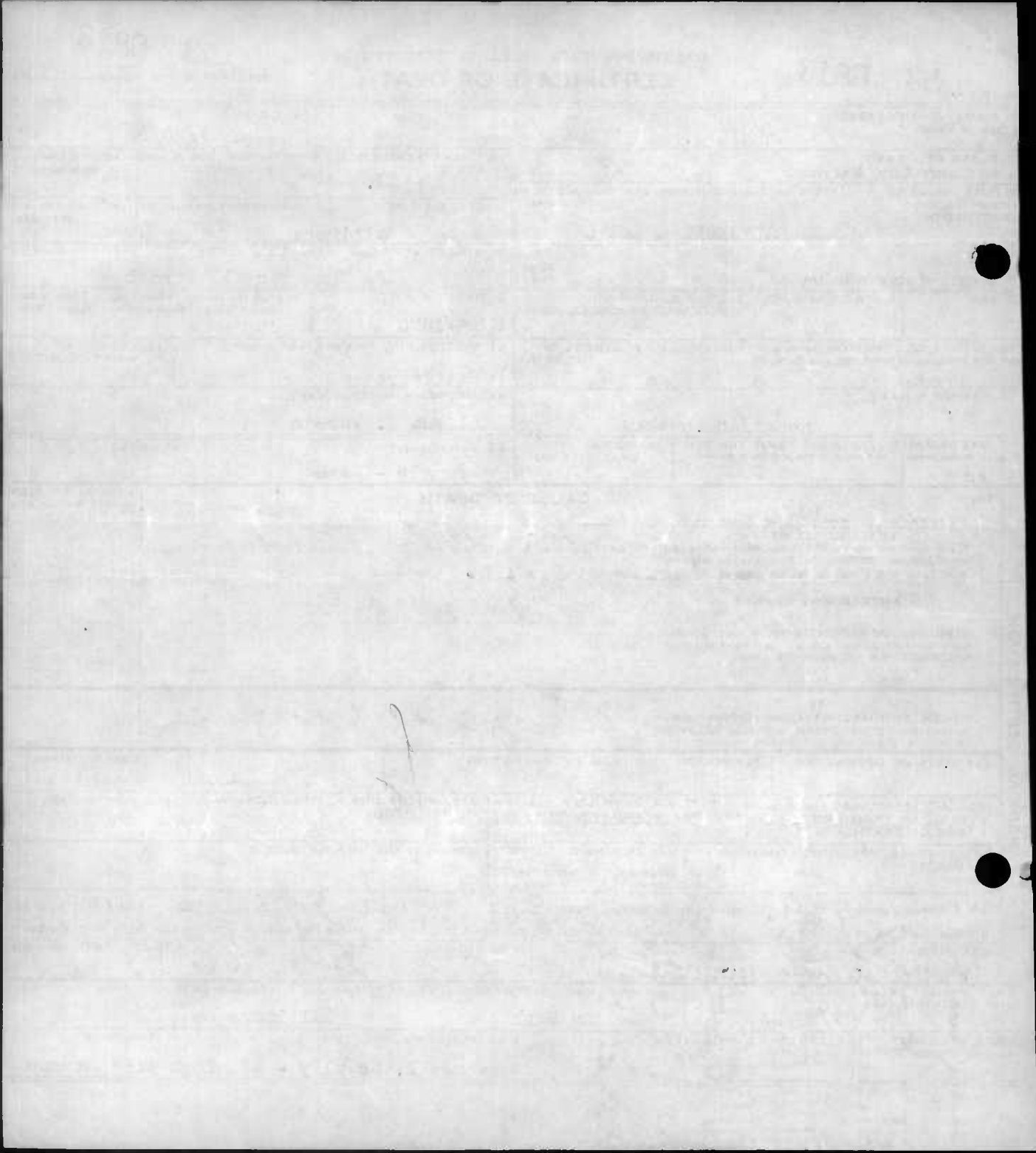
L-532

53 6813

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6813  
Registered No.

|   |                              |   |  |   |   |
|---|------------------------------|---|--|---|---|
| BIRTH NO.   |                              | 1. NAME OF DECEASED<br>(Type or Print) <b>CARRIE E. LINTHICUM</b>   |  | 2. DATE OF DEATH <b>7/25/53</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY  |  |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>43 SOUTH BALTIMORE GENERAL</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 24-04</b>  |  |   |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                              | D. STREET ADDRESS (If rural, give location)<br><b>161 East Randall Street</b>   |  |   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>   |  | 8. DATE OF BIRTH<br><b>5/16/1875</b>  | 9. AGE (in years last birthday) <b>78</b><br>If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                       |   |
| 13. FATHER'S NAME<br><b>Zachariah Meushaw</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Linda F. Turpin</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Family - Same</b>                                       |   |
| 18. <b>570.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |                              | CAUSE OF DEATH<br>(A) <b>Mesenteric Thrombosis</b><br>DUE TO<br>(B) <b>Generalized atherosclerosis</b><br>DUE TO<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Arteriosclerosis Heart Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION<br><b>7</b>  |                              | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                              | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                              | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>July 20th, 1953</b> , to <b>July 25, 1953</b> , that I last saw the deceased alive on <b>July 24, 1953</b> , and that death occurred at <b>6-27 PM.</b> , from the causes and on the date stated above.   |                              |   |  |   |   |
| 23A. SIGNATURE<br><b>Osvaldo Benos Jimenez</b>  |                              | 23B. ADDRESS<br><b>Scott Hall Genl Hosp.</b>  |  | 23C. DATE SIGNED<br><b>7-26-53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>   |                              | 24B. DATE<br><b>7/29/53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                            |   |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore</b>   |                              | 25. FUNERAL DIRECTOR ADDRESS<br><b>James L. McCully - 130 East Fort Avenue</b>  |  |   |   |

MEDICAL CERTIFICATION





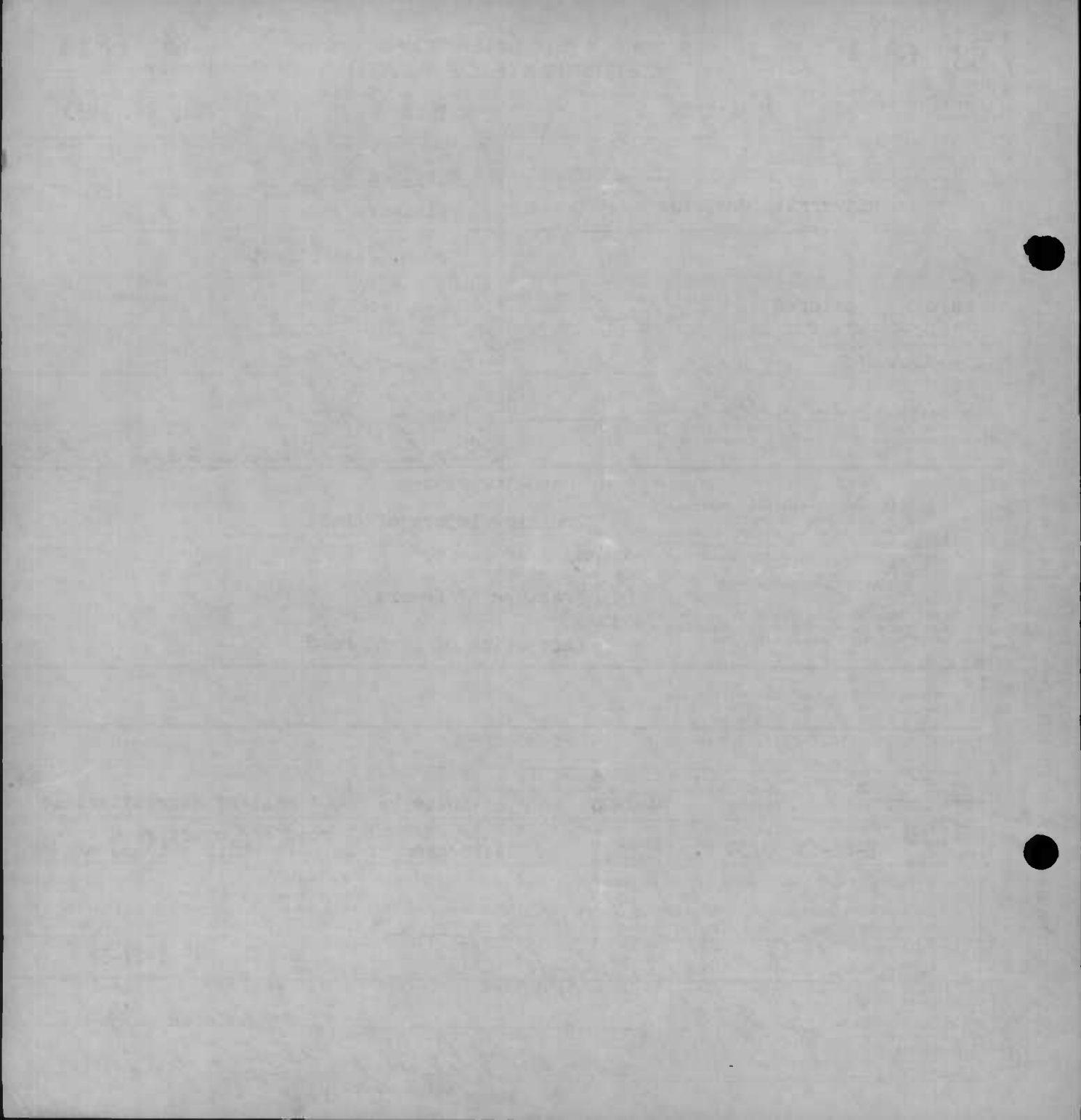
W-325  
53 6814BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6814  
Registered No.

BIRTH NO.

|   |                                    |   |   |  |  |
|---|------------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALEXANDER</b>   |                                    | <b>WATSON</b>   |   | 2. DATE OF DEATH<br><b>July 26, 1953</b>     |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>  |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>12-04</b>     |  |  |
| c. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>330 E. 21st Street</b>  |  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>Sept 22, 1923</b>  | 9. AGE (In years last birthday)<br><b>29</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |                                    |   | 11. BIRTHPLACE (State or foreign country)<br><b>Farmville Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>Richard Watson</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jones</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)      |                                    |   | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT<br><b>Stardine Watson</b>   |                                    |   | ADDRESS<br><b>330 E 21st St</b>   |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>E873.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Crushing Injury of Chest</b><br>(A) <b>XXXXX</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <b>Fracture of femurs</b><br><b>XXXXX</b><br>(C) <b>Laceration of right hand</b>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>highway</b>        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Route 99, 500' east of Marriottsville Rd.</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>7-26-53 3:30 P.m.</b>   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>road and overturned passenger in auto which skidded off of</b>                              |  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Joseph G. Jachimczyk</b>   |  | 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....                        |  | 23C. DATE SIGNED<br><b>7-27-53</b>   |  |
| 24A. BURIAL, CREATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY   |  |
| <b>Removed July 27/53</b>   |  | <b>July 27/53</b>   |  | <b>Farmville Va</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>Wm Robert Elliott &amp; Daughters</b>   |  |
| <b>VS 151</b>   |  | <b>N-88 r. 2</b>  |  | <b>97099 1129 N. Caroline St.</b>  |  |



E-430  
53 6815BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6815  
Registered No.

H NO.

NAME OF DECEASED  
(Last and first name)

Alberta Mildred Elliott

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

3603 W. Garrison Ave.,

40- Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

male White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
MarriedUSUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)  
housewife10B. KIND OF BUSINESS OR  
INDUSTRY

FATHER'S NAME

Albert Eichelberger

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

212-05-2529

8. DATE OF BIRTH

Apr. 29, 1896

9. AGE (in years  
last birthday)

57

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Clara Douglas

17. INFORMANT

ADDRESS

Mr. Lewis A. Elliott 3603 W. Garrison

B. 4201

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute Coronary Occlusion

26 July '53

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Recurrent Angina Pectoris

1940

(C) Arteriosclerotic C. V. Disease

?

Hypertension

?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1940, to 26 July, 1953, that I last saw the  
deceased alive on 26 July, 1953, and that death occurred at 11:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

25B. FUNERAL DIRECTOR

ADDRESS

27 1953

Huntington Williams, M.D.

G. Howard Strong 3207 W. North Ave.,

VS 150

Dr. J. E. Mene Jr.

5W 29th St. Rm 5

10 AM

Call back

office hrs. 2 PM

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6816  
Registered No. \_\_\_\_\_

W-435  
53 6816

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Carrie Weltner</b>   |                                  | 2. DATE OF DEATH<br><b>July 25, 1953</b>   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____                        |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Edgewood St</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>20-07</b>  |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>65- Yrs. Mos. Days</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>413 Edgewood St.,</b>  |   |
| 7. SEX<br><b>Female</b>  | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 10. DATE OF BIRTH<br><b>Sept. 6, 1887</b> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-wife</b>  |                                  | 12. AGE (in years last birthday)<br><b>65</b>  |   |
| 13. FATHER'S NAME<br><b>William H. Tice</b>  |                                  | 14. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. CITIZEN OF WHAT COUNTRY?<br><b>Md.</b>   |   |
| 17. SOCIAL SECURITY NO.<br><b>none</b>   |                                  | 18. MOTHER'S MAIDEN NAME<br><b>Mollie S. Pease</b>   |   |
| 19. INFORMANT<br><b>Mr. Frederick Weltner</b>  |                                  | 20. ADDRESS<br><b>413 Edgewood St.</b>   |   |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>416X and 170X</b>   |                                  | 22. CAUSE OF DEATH<br>(A) <b>Congestive Heart Failure</b><br>DUE TO<br>(B) <b>Rheumatic and Arteriosclerotic Heart Disease.</b><br>DUE TO<br>(C) _____ |   |
| 23. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Generalized Carcinomatosis secondary to Carcinoma of Breast</b>   |                                  | 24. INTERVAL BETWEEN ONSET AND DEATH   |   |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  | 26. _____  |   |
| 27. 19A. DATE OF OPERATION<br><b>0</b>   |                                  | 28. 19B. MAJOR FINDINGS OF OPERATION   |   |
| 29. 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  | 30. _____  |   |
| 31. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  |                                  | 32. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 33. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  | 34. 21D. HOW DID INJURY OCCUR?   |   |
| 35. 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 36. 21F. HOW DID INJURY OCCUR?   |   |
| 37. 22. I hereby certify that I attended the deceased from <b>July 26, 1952</b> to <b>July 25, 1953</b> , that I last saw the deceased alive on <b>July 25, 1953</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above. |                                  |  |   |
| 38. 23A. SIGNATURE<br><b>James R. Smith</b>  |                                  | 39. 23B. ADDRESS<br><b>1975 W. Baltimore St.</b>   |   |
| 40. 23C. DATE SIGNED<br><b>July 25</b>   |                                  | 41. _____  |   |
| 42. 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 43. 24B. DATE<br><b>7-28-1953</b>  |   |
| 44. 24C. NAME OF CEMETERY OR CREMATORY<br><b>Western</b>   |                                  | 45. 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |   |
| 46. DATE RECEIVED BY LOCAL REGISTRAR   |                                  | 47. REGISTRAR'S SIGNATURE  |   |
| 48. FUNERAL DIRECTOR<br><b>G. Howard Strong</b>  |                                  | 49. ADDRESS<br><b>3207 W. North Ave.,</b>  |   |





M-536  
53 6817BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 53 6817

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RISA MUNDER

2. DATE  
OF  
DEATH

July 26, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore, Md*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*Montebello State Hospital*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Hagerstown*

D. STREET ADDRESS (If rural, give location)

*1605 Va. Ave.*

c. Length of stay in Baltimore

3

Yes.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*May 28, 1880*9. AGE (In years  
last birthday)

73

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Austria*12. CITIZEN OF  
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

*unknown*

14. MOTHER'S MAIDEN NAME

*unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*unk.*16. SOCIAL  
SECURITY NO.*unk.*

17. INFORMANT

*Hospital Record*

ADDRESS

18.

*151 X and 260 X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

*Metastatic Carcinoma of Liver**about 1 yr.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

*Carcinoma of the Stomach**more than  
4 yrs.*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.*Diabetes Mellitus**many yrs.*

19A. DATE OF OPERATION

*7/27/51*19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED.*Carcinoma of Stomach*IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 16, 1949*, 19\_\_, to *July 26*, 19*53*, that I last saw the  
deceased alive on *July 26*, 19*53*, and that death occurred at *10:25 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Daniel Rai*

23B. ADDRESS

*Montebello Hospital*

23C. DATE SIGNED

*July 27, 1953*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Removal*

24B. DATE

*7/27/53*

24C. NAME OF CEMETERY OR CREMATORY

*Rose Hill Cemetery*

24D. LOCATION (City, town, or county)

*Hagerstown, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston W. Walshaw, M.D.*

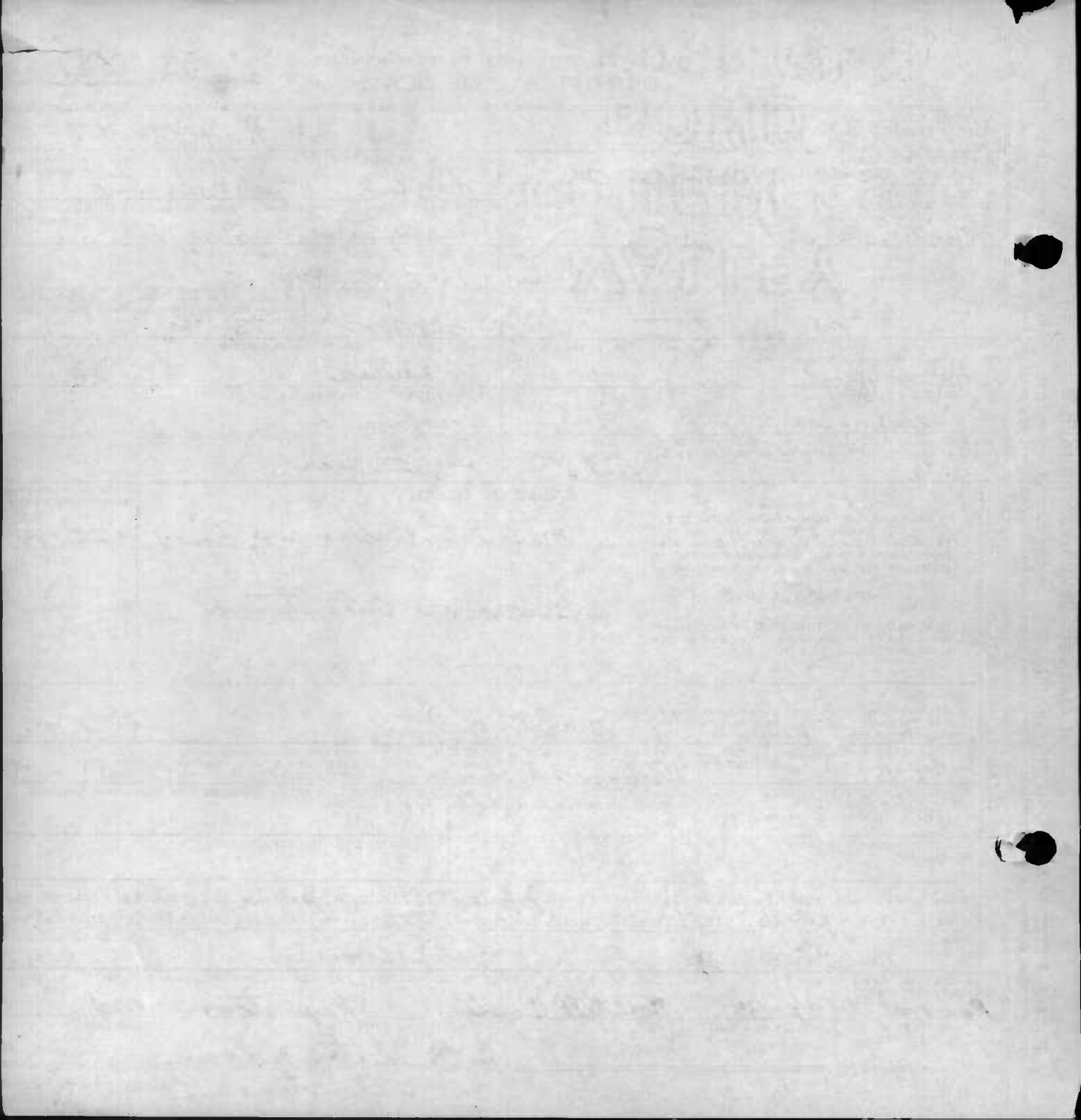
25. FUNERAL DIRECTOR

*C. M. Lister & Sons*

ADDRESS

*305 North Potomac St. Hagerstown, Md.*

JUL 27 1953



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

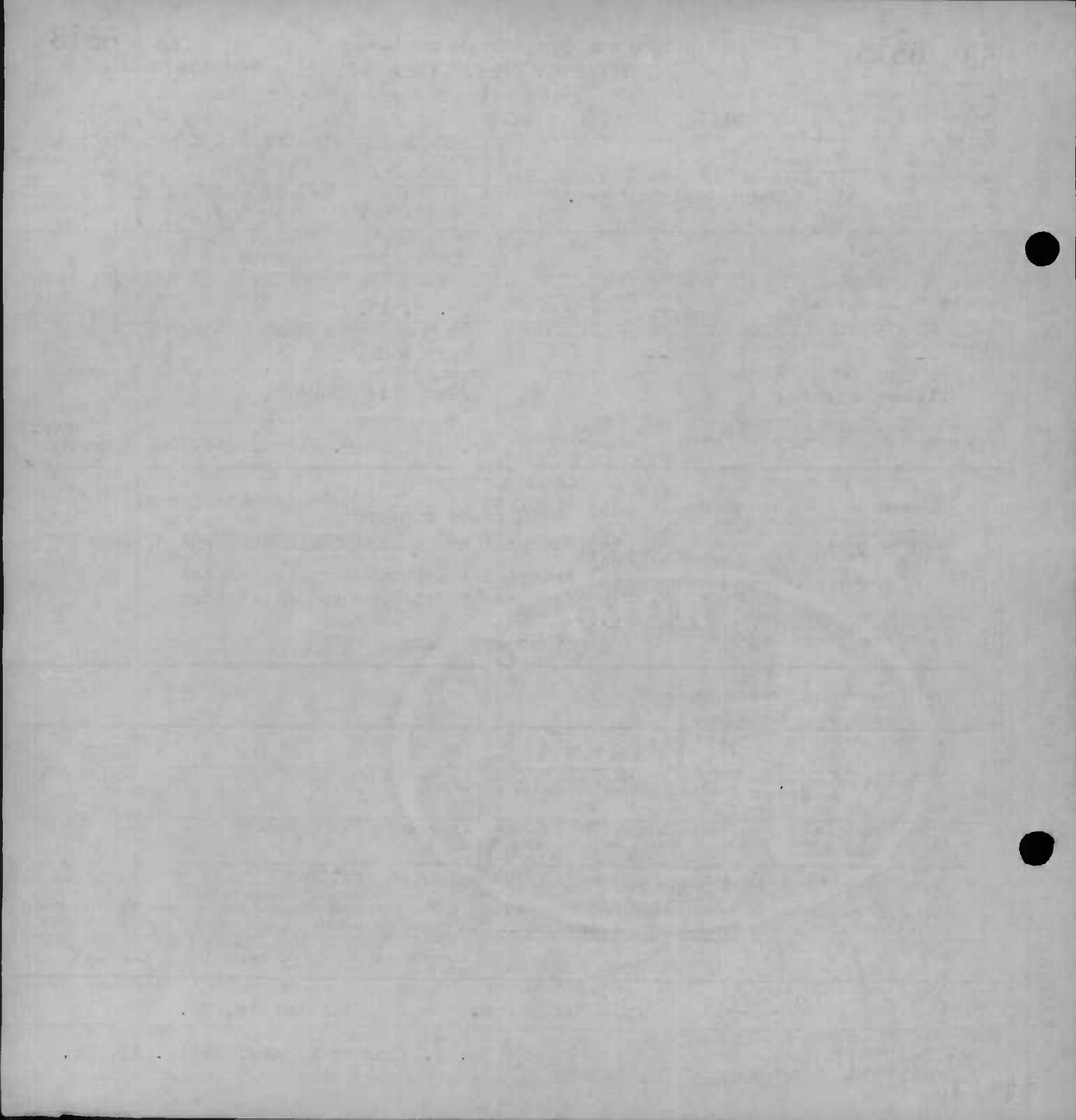
MARGIN RESERVED FOR BINDING

B-450  
53 6818

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6818  
Registered No.

|  |                           |   |                                  |  |  |
|--|---------------------------|---|----------------------------------|--|--|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print) GWENDOLYN EVA BLOHM  |                                  | 2. DATE OF DEATH<br>July 26, 1953  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY   |                                  |  |  |
| B. FULL NAME OF (not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION 3106 Liberty Heights Ave.   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-10   |                                  |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br>3807 Granada Avenue  |                                  |  |  |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married  | 8. DATE OF BIRTH<br>Aug. 6, 1910 | 9. AGE (In years last birthday)<br>42                                    | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>--  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>--   |                                  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                           | 13. FATHER'S NAME<br>William McDannel   |                                  | 14. MOTHER'S MAIDEN NAME<br>Jeannette Downey                             |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |                           | 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS<br>Mr. William H. Blohm, Jr.-3807 Granada ave.     |  |
| 18. 330X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                           | CAUSE OF DEATH<br>(A) Aneurysm of left middle cerebral artery with acute rupture<br>(B) Subdural and subarachnoid hemorrhage, left<br>(C) Arteriolar nephrosclerosis, marked<br>(D) Cardiac hypertrophy and dilatation<br>(E) Pulmonary Edema<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |   |                                  |  |  |
| 19A. DATE OF OPERATION   |                           | 19B. MAJOR FINDINGS OF OPERATION  |                                  |  |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |   |                                  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                           |   |                                  |  |  |
| 23A. SIGNATURE<br>Joseph A. Jackson, M.D.  |                           | 23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....  |                                  | 23C. DATE SIGNED<br>7-27-53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                           | 24B. DATE<br>7-29-53  |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.                   |  |
| 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Md.   |                           |   |                                  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>7/27/53  |                           | REGISTRAR'S SIGNATURE   |                                  | 25. FUNERAL DIRECTOR ADDRESS<br>Wm. J. Tickner & Sons, Balto. 17, Md.    |  |



## BALTIMORE CITY HEALTH DEPARTMENT

53 6819

Registered No.

BIRTH NO.

52-01557

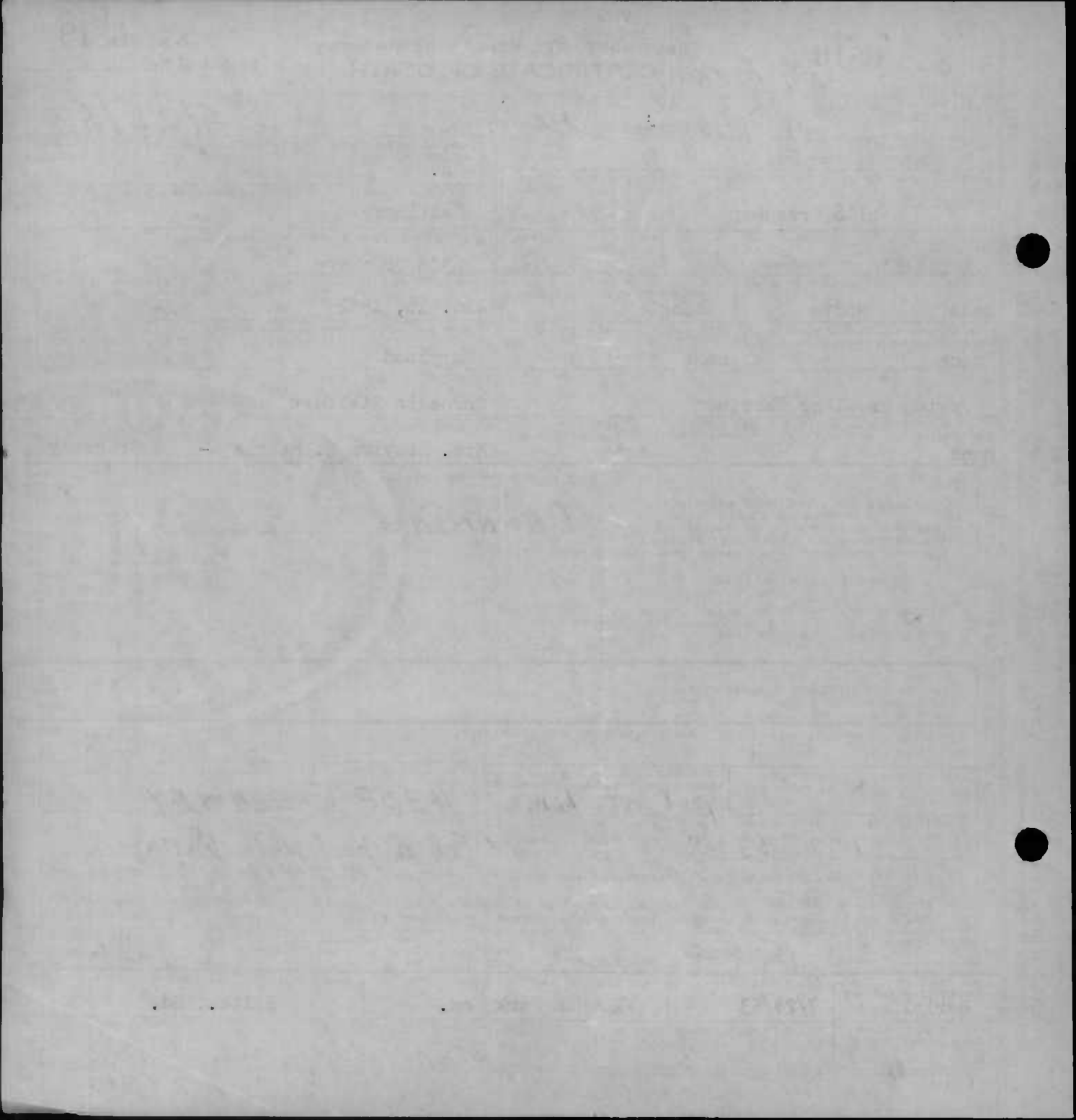
## CERTIFICATE OF DEATH

|   |                                  |  |   |  |  |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William Edward HARRISON</b>   |                                  |  | 2. DATE OF DEATH<br><b>7/25/53</b>  |  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY |  |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4308 Greenway</b>   |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-11</b>                    |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |  | d. STREET ADDRESS (If rural, give location)<br><b>4308 Greenway</b>   |  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b> | 8. DATE OF BIRTH<br><b>Jan. 16, 1952</b>  |  | 9. AGE (In years last birthday)<br><b>18</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>              |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                 | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>Drayton Crowther Harrison</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Cornelia Stalfort</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>none</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>                           | 17. INFORMANT ADDRESS<br><b>Mrs. Drayton C. Harrison-4308 Greenway</b>  |  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>E929.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) DROWNING</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br><b>(B)</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO  |  |                                  |
| <b>(C)</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|   |   |  |  |   |
|---|---|--|--|---|
| 19a. DATE OF OPERATION  |   | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>yard at home</b>  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>4308 GREENWAY</b>                         |  |   |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>7 25 53 130m.</b>   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>Fell in pool while playing</b>  |  |   |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |  |  |   |
| 23a. SIGNATURE<br><b>R. B. Fisher</b>   |   | 23b. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. |  | 23c. DATE SIGNED<br><b>7-26-53</b>  |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24b. DATE<br><b>7/28/53</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b> | 24d. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR                           |                             | 25. FUNERAL DIRECTOR<br><b>Wm. J. Lickner &amp; Sons</b>      | ADDRESS<br><b>Balto., Md.</b>                                       |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Jr.</b>   |                             |   |   |





B-620  
53 6820

53 6820

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|   |                                  |   |  |  |  |   |  |  |
|---|----------------------------------|---|--|--|--|---|--|--|
| BIRTH NO. _____   |                                  |   | 1. NAME OF DECEASED<br>(Type or Print) <i>Catherine A. Burke</i>   |  |  | 2. DATE OF DEATH<br><i>7/26/53</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Ind.</i> B. COUNTY _____  |  |  |   |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>105 N. Monroe St.</i>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 20-01</i>   |  |  |   |  |  |
| c. Length of stay in Baltimore <i>43</i> Yrs. Mos. Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>105 N. Monroe St.</i>  |  |  |   |  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 8. DATE OF BIRTH<br><i>3/27/1890</i>   |  | 9. AGE (In years last birthday)<br><i>63</i> |   | 10. Under 1 Year Months: Days: Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>House wife</i>  |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>  |  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Ireland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |
| 13. FATHER'S NAME<br><i>Martin Mulligan</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Catherine</i>   |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)      |  |  |
| 16. SOCIAL SECURITY NO. _____   |                                  |   | 17. INFORMANT<br><i>Mr Richard J. Burke</i>  |  |  | ADDRESS <i>105 N. Monroe St.</i>  |  |  |
| 18. <i>420.1</i> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary Artery Occlusion</i><br>DUE TO (A) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Hypertension - Arteriosclerosis</i><br>DUE TO (B) <i>none</i><br>(C) _____ |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 hr.</i><br><i>5 yrs ??</i>  |  |  | OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  |
| 19A. DATE OF OPERATION<br><i>none</i>   |                                  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                     |  |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                                  |   | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |  |  |
| 21F. HOW DID INJURY OCCUR?  |                                  |   | 22. I hereby certify that I attended the deceased from <i>July 1, 1953</i> , to <i>July 26, 1953</i> , that I last saw the deceased alive on <i>July 25, 1953</i> , and that death occurred at <i>5 p.m.</i> , from the causes and on the date stated above. |  |  | 23A. SIGNATURE<br><i>John J. Cavan</i>  |  |  |
| 23B. ADDRESS<br><i>1933 W. Dulles St.</i>   |                                  |   | 23C. DATE SIGNED<br><i>7/28/53</i>   |  |  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  |
| 24B. DATE<br><i>7/30/53</i>   |                                  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral Cem</i>   |  |  | 24D. LOCATION (City, town, or county) (State)<br><i>4300 Old Frederick Rd.</i>                                |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                  |   | REGISTRAR'S SIGNATURE<br><i>John J. Cavan</i>  |  |  | 25. FUNERAL DIRECTOR<br><i>John J. Cavan + Son Hollins</i>  |  |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 27 1953

*Huntington Williams, M.D.*

WALTER

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

 Registered No. **53 6821**

 1. NAME OF DECEASED  
(Type or Print)

**Charlotte Banner**

 2. DATE  
OF  
DEATH

**July 18, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**Med. Csl B**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**JOHNS HOPKINS HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**
**6-04**

D. STREET ADDRESS (If rural, give location)

**1803 Samley St.**

c. Length of stay in Baltimore

 Yrs.  
Mos.  
Days

5. SEX

**Female**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**5 - 04**

9. AGE (In years last birthday)

**49**

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**?**

14. MOTHER'S MAIDEN NAME

**?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**JOHNS HOPKINS HOSPITAL**

 18. **600.0 I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Hyperchloremic acidosis**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

**Metastatic carcinoma**  
**Bilateral pyelonephritis**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

 YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

 WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from **7-18**, 19**53**, to **7-18**, 19**53**, that I last saw the deceased alive on **7-18**, 19**53**, and that death occurred at **9:30 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Henry H. Wagner Jr.**

23B. ADDRESS

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

**7/21/53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**UNIVERSITY MEDICAL SCHOOL JUL 27 1953**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

Hyperbolic Curve  
Bilateral Symmetry  
Bilateral Symmetry

7/1/22

-654

6822

H NO.

53-15917

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

6822

NAME OF DECEASED  
(or Print)

Baby Boy ARNOLD

2. DATE  
OF  
DEATH

7/12/53

PLACE OF DEATH:

Baltimore City, Maryland

Sinai

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Sinai

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md

Balt.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Parkville

53-00

D. STREET ADDRESS (If rural, give location)

9731 Hartford Rd #34

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

7/12/53

9. AGE (in years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

8

10. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sinai

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

DALE

Arnold

14. MOTHER'S MAIDEN NAME

Cladys Lee

Billingsley

13. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

I. 776x I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Prematurity

DUE TO

8 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

3 - 2 1/4

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/12, 1953 to 7/12, 1953, that I last saw the  
deceased alive on 7/12, 1953, and that death occurred at 8:13 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Malcolm L. Robbins M.D.

23B. ADDRESS

Sinai Hoop

23C. DATE SIGNED

7/12

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL JUL 25 1953

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

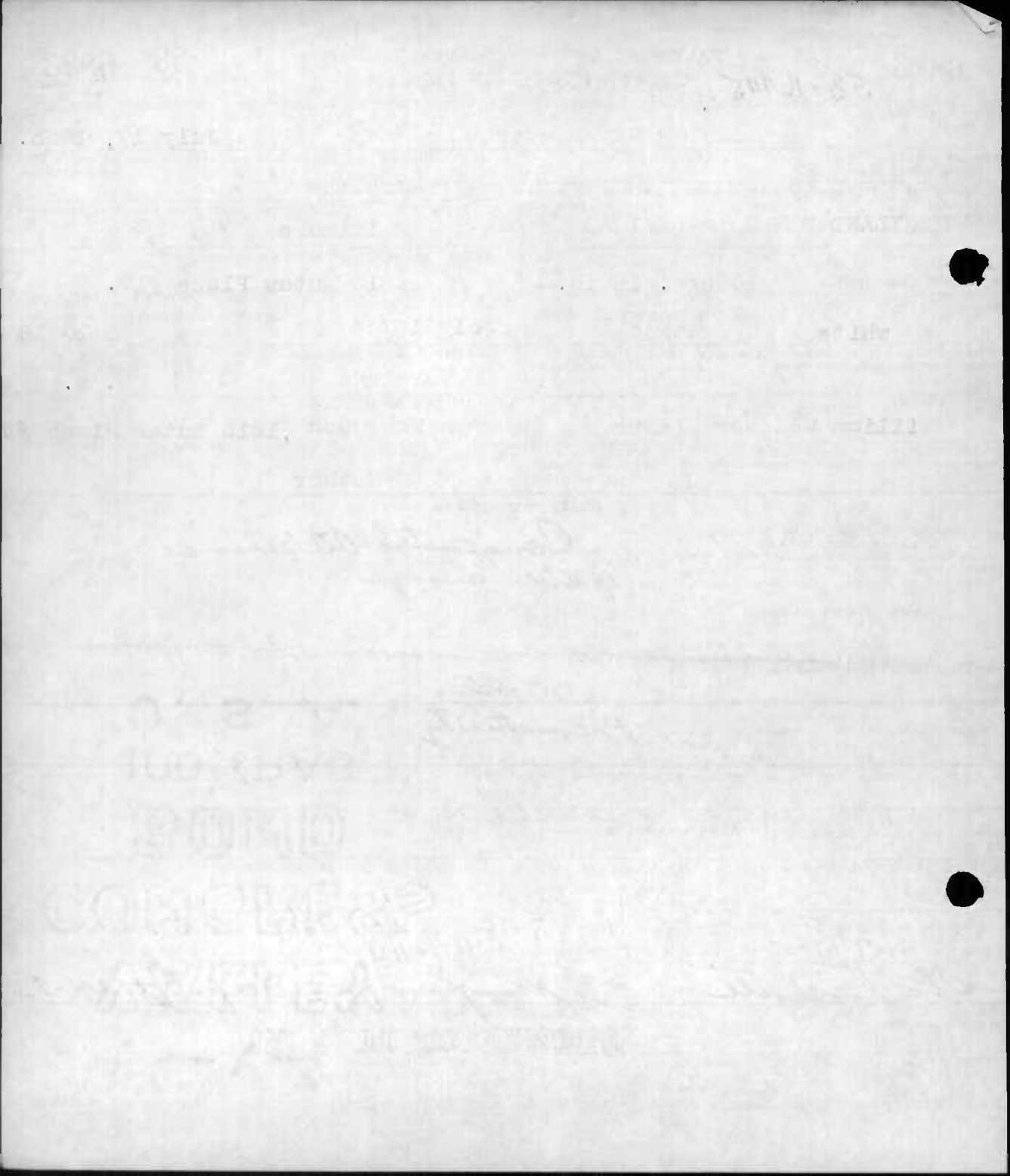
ADDRESS

Huntington Williams, M.D.





| BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 53 6823  |  |
|--|--|---|--|
| 6823 53-16445  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED (or Print)<br>William Ray Weaver   |  | 2. DATE OF DEATH<br>July 17, 1953.  |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE<br>Maryland       |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>MARYLAND GENERAL HOSPITAL  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 14-01                     |  |
| 6. COLOR OR RACE<br>white  |  | D. STREET ADDRESS (If rural, give location)<br>1615 Eutaw Place #17.  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>single  |  | 8. DATE OF BIRTH<br>July 16/53  |  |
| 9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)   |  | 9. AGE (in years last birthday)<br>10 18  |  |
| 10. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 13. MOTHER'S MAIDEN NAME<br>Emma Mae Bush   |  |
| 14. FATHER'S NAME<br>William Woodrow Weaver  |  | 15. INFORMANT<br>Mother   |  |
| 16. SOCIAL SECURITY NO.  |  | 17. ADDRESS   |  |
| 18. CAUSE OF DEATH<br>Congenital Atelectasis of the Lung   |  | 19. INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20. ANTECEDENT CAUSES<br>Prematurity   |  | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
| 22. DATE OF OPERATION  |  | 23. MAJOR FINDINGS OF OPERATION   |  |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 25. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                            |  |
| 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 27. INJURY OCCURRED   |  |
| 28. HOW DID INJURY OCCUR?  |  | 29. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)  |  |
| 30. I hereby certify that I attended the deceased from 7-16, 1953 to 7-17, 1953 that I last saw the deceased alive on 7-17-53, 1953, and that death occurred at 12:35 PM from the causes and on the date stated above. |  | 31. SIGNATURE<br>J. P. Vicente  |  |
| 32. ADDRESS<br>Maryland Gen. Hosp.   |  | 33. DATE SIGNED<br>7-24-53  |  |
| 34. BURIAL, CREMATION, REMOVAL (Specify)   |  | 35. NAME OF CEMETERY OR CREMATORY   |  |
| 36. LOCATION (City, town, or county) (State)   |  | 37. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  |
| 38. FUNERAL DIRECTOR<br>Huntington Williams, M.D.  |  | 39. ADDRESS   |  |



-240  
53 6824BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6824  
Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print)

John Cichelli

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:  
Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived or institution: residence  
before admission)

A. STATE

B. COUNTY

FULL NAME OF  
SPITAL OR  
STITUTION

Mercy Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

27-09

D. STREET ADDRESS (If rural, give location)

1320 Pentwood Road #12

Length of stay in Baltimore

40 yrs.

Yrs.  
Mos.  
DaysSEX 6. COLOR OR RACE 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Male

White

Married

8. DATE OF BIRTH

Oct 18, 1890

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months Days Hours Min.A. USUAL OCCUPATION (Give kind of  
doce during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR  
INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

Andrew Cichelli

14. MOTHER'S MARDEN NAME

Philomena Liberatori

WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-03-0715

17. INFORMANT

ADDRESS

Wife &amp; Son 1320 Pentwood Rd #12 Balt.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Chronic Myeloid Leukemia

DUE TO

2 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1953, to July 26, 1953, that I last saw the  
deceased alive on July 25, 1953, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 27 1953

Huntington Williams, M.D.

Francis Della Noce 3219 Hight St

VS 150

59046

1968

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

February 1, 1968

Dear Sir:

I am pleased to

acknowledge the

receipt of your

letter of the

10th instant.

Enclosed for

you are two

copies of the

report of the

Committee on

the subject of

the proposed

amendment to

the Federal

Food, Drug,

and Cosmetic

Administration

Act.

Very truly yours,

Secretary

Enclosure

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6825**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CARL

PARKS

2. DATE OF DEATH  
July 27, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Virginia

B. COUNTY

5. FULL NAME OF (not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Crockett

D. STREET ADDRESS (If rural, give location)

6. Length of stay in Baltimore

Yrs.  
Mos.  
Days

7. SEX

male

8. COLOR OR RACE

white

9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

10. DATE OF BIRTH

7/9/1918

11. AGE (In years last birthday)

35

12. If Under 1 Year

Months: Days

13. If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

Tann

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jerome Parks.

14. MOTHER'S MAIDEN NAME

Media Testament

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

231-184342

17. INFORMANT

Alvin Parks

ADDRESS

18. E812.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

XXXXX

ANTECEDENT CAUSES

(B) Contusion Foci of Brain

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Fractures of left elbow, left femur and left tibia and fibula

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eastern Blvd. &amp; Langley Rd. 53-00

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

7-26-53 10:05 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by automobile

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jochims

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

7-27-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

7/28/53

24C. NAME OF CEMETERY OR CREMATORY

Huntington

24D. LOCATION (City, town, or county)

Wyllsville Va

(State)

DATE RECEIVED BY LOCAL REGISTRAR

JUL 28 1953

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Brydowski

ADDRESS

1407 Eastern Ave

VS 151

N-804.2

82610

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1538

72

THE UNIVERSITY OF CHICAGO

LIBRARY OF THE DIVISION OF THE PHYSICAL SCIENCES

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6826

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6826

H NO.

NAME OF DECEASED  
(or Print)

SCULLEY, Mrs ALICE ESTELLE

2. DATE  
OF  
DEATH

7-27-53

AGE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

Church Home and Hospital

HOSPITAL OR

INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

Carroll

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Westminster

D. STREET ADDRESS (If rural, give location)

56 Westmoreland

Length of stay in Baltimore

one day

Free  
Mon.  
Days

SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 3 1874

9. AGE (in years  
last birthday)

78

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

James I. Wickes  
Wickes

14. MOTHER'S MAIDEN NAME

Miss Agnes Pryor

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

no

16. SOCIAL  
SECURITY NO.

unknown

17. INFORMANT

ADDRESS

Church Home Hospital Balto, Md.

B.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Gangrene of leg

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Atherosclerosis

(C)

Desquamation

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26, 1953, to 7/27, 1953, that I last saw the  
deceased alive on 7/27, 1953 and that death occurred at 2:55 p.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

Dr. F. Season

M. D.

Church Home &amp; Hospital

7/27/53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

Burial

July 30/53

Meadow Branch

Carroll co

RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

H. 28133

Huntington

H. Bonhard, son Westminster Md

VS 150

100

UNITED STATES DEPARTMENT OF AGRICULTURE

1918

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.  
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]



UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased: [Faint text, illegible]

2. Sex: [Faint text, illegible]

3. Age: [Faint text, illegible]

4. Date of birth: [Faint text, illegible]

5. Place of birth: [Faint text, illegible]

6. Date of death: [Faint text, illegible]

7. Time of death: [Faint text, illegible]

8. Cause of death: [Faint text, illegible]

9. Place of death: [Faint text, illegible]

10. Signature of physician: [Faint text, illegible]

11. Signature of registrar: [Faint text, illegible]

12. Signature of informant: [Faint text, illegible]

13. Name of informant: [Faint text, illegible]

14. Address of informant: [Faint text, illegible]

15. Date of completion: [Faint text, illegible]

6828

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6828  
Registered No.

H. NO.

NAME OF DECEASED  
(or Print)

Joseph Luber

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:

Baltimore City, Maryland 1211 Valley St

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

1211 Valley St

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE

Male White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 1878

9. AGE (In years last birthday)

74

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

George M. Luber

14. MOTHER'S MAIDEN NAME

Annie Maurer

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Fred. Dierkin 6200 McClean Blvd.

B. 442X1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) congestive heart failure

3-4 mos

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis cordis -  
vascular renal disease

?

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 1946 to 26 July, 1953, that I last saw the deceased alive on 24 July, 1953, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25. FUNERAL DIRECTOR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Huntington Williams, M.D.

Rita Wiedefeld 900 E. Biddle St





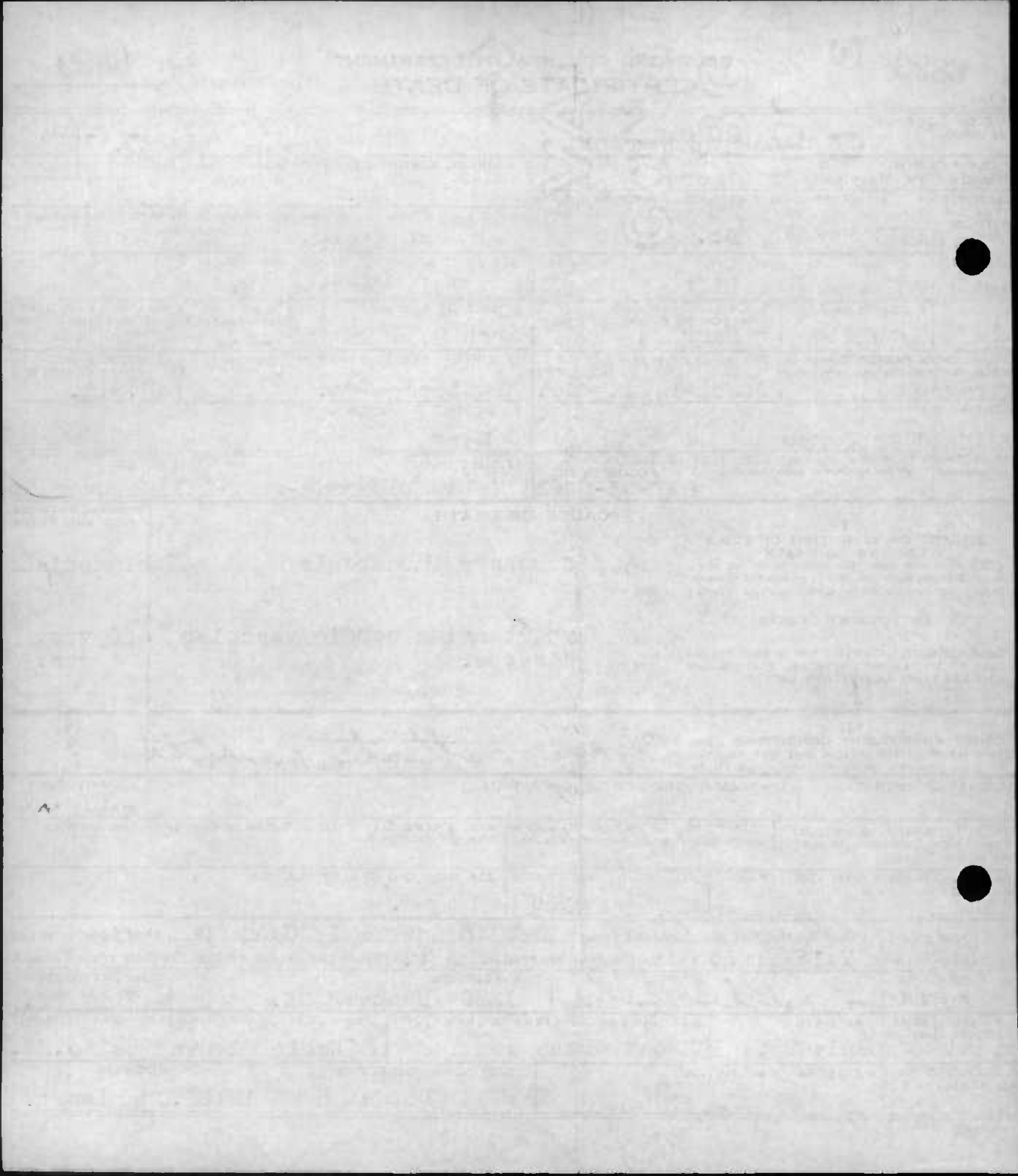
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6829

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6829  
Registered No.

|   |  |  |  |
|---|--|--|--|
| 1. NO.  |  | 2. DATE OF DEATH July 25, 1953   |  |
| 3. NAME OF DECEASED (or Print) Raymond A. McDorman  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |  |
| 5. PLACE OF DEATH: Baltimore City, Maryland Baltimore   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore L3-01                    |  |
| 6. ALL NAME OF (If not in hospital or institution, give street address or location)<br>1311 Hanover St.   |  | D. STREET ADDRESS (If rural, give location)<br>1311 Hanover St.  |  |
| 7. Length of stay in Baltimore Life   |  | 8. DATE OF BIRTH March 9, 1899   |  |
| 9. 6. COLOR OR RACE white   |  | 9. AGE (In years last birthday) 54yrs.   |  |
| 10. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married   |  | 11. BIRTHPLACE (State or foreign country) Baltimore Md.  |  |
| 12. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) Insurance   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME Chibald McDorman  |  | 14. MOTHER'S MAIDEN NAME Mary ?  |  |
| 15. HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none  |  | 16. SOCIAL SECURITY NO. 217-03-6062  |  |
| 17. INFORMANT   |  | ADDRESS Helen McDorman-wife-1311 Hanover St.   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) Coronary Thrombosis<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) Hypertensive cardio vascular disease.<br>(C) ?<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic asthmatic bronchitis ? |  | INTERVAL BETWEEN ONSET AND DEATH<br>Immediate<br>5 yrs.<br>4 mos.  |  |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. HOW DID INJURY OCCUR?   |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |
| 22. I hereby certify that I attended the deceased from 3/2/48, 19, to 7/26/53, 19, that I last saw the deceased alive on 7/15/53, and that death occurred at 5 A.M., from the causes and on the date stated above.  |  |  |  |
| 23A. SIGNATURE Harry Deibel   |  | 23B. ADDRESS 1226 Hanover St.  |  |
| 23C. DATE SIGNED 7/27/53  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE July 28, 1953  |  |
| 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery  |  | 24D. LOCATION (City, town, or county) (State) Ritchie Highway Balto. Md.   |  |
| 25. FUNERAL DIRECTOR ADDRESS KRAUSE FUNERAL HOME 1216 S. Charles St.  |  |  |  |

45073



*Death Case*

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 *Released to hospital* Registered No. *53-6830*

BIRTH NO. *33*

1. NAME OF DECEASED (Type or Print) *Jessie Sullens*

2. DATE OF DEATH *JUL 27 1953*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION *JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Md.*  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 7-02*

D. STREET ADDRESS (If rural, give location)  
*616 N. Glover St.*

c. Length of stay in Baltimore *Life*

5. SEX *female*

6. COLOR OR RACE *white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *married*

8. DATE OF BIRTH *12-21-92*

9. AGE (In years last birthday) *61*

10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *Baltimore*

12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *? Mace*

14. MOTHER'S MAIDEN NAME *Mary Meehan*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *JOHNS HOPKINS HOSPITAL*

18. *260X and E 902.0* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) *Coronary Occlusion*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. *Generalized Arteriosclerotic C-V Disease*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. *Rheumatic Arthritis + recent Fractured Hip*

19A. DATE OF OPERATION *July 24, 1953*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED *Fractured Hip*

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., id or about home, farm, factory, street, office bldg., etc.) *Home*

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? *Home - 616 N. Glover St.*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY *July 24, 1953*

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? *pt. fell from chair*

22. I hereby certify that I attended the deceased from *7-24-*, 19*53*, to *7-27-*, 19*53*, that I last saw the deceased alive on *7-27-*, 19*53*, and that death occurred at *3A* m., from the causes and on the date stated above.

23A. SIGNATURE *George C. D. D.*

23B. ADDRESS *JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED *July 27, 1953*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *7-30-53*

24C. NAME OF CEMETERY OR CREMATORY *Balto - Md.*

24D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *JUL 28 1953*

REGISTRAR'S SIGNATURE *Huntington*

25. FUNERAL DIRECTOR ADDRESS *Lilly & Zeiler, Inc 403 S. Wolfe Street*

VS 150

*N-8200*

CERTIFICATE OF DEATH

John

Mr.

Baltimore

111 N. Howard

11

11

11

11

11

11

11

11

11

11

11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6834

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE J. BREWER

2. DATE OF DEATH

7-26-53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO 1-04

d. STREET ADDRESS (If rural, give location)

826 S. KENWOOD

c. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6-15-20

9. AGE (in years last birthday)

33

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore -

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank W. Stasiemski

14. MOTHER'S MAIDEN NAME

Rose ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Arthur B. Brewer

ADDRESS

same

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO coronary sclerosis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Francis J. Jannozeski

23b. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED 7-26-53

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

7-30-53

24c. NAME OF CEMETERY OR CREMATORY

Holy Cross

24d. LOCATION (City, town, or county)

Balto - Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

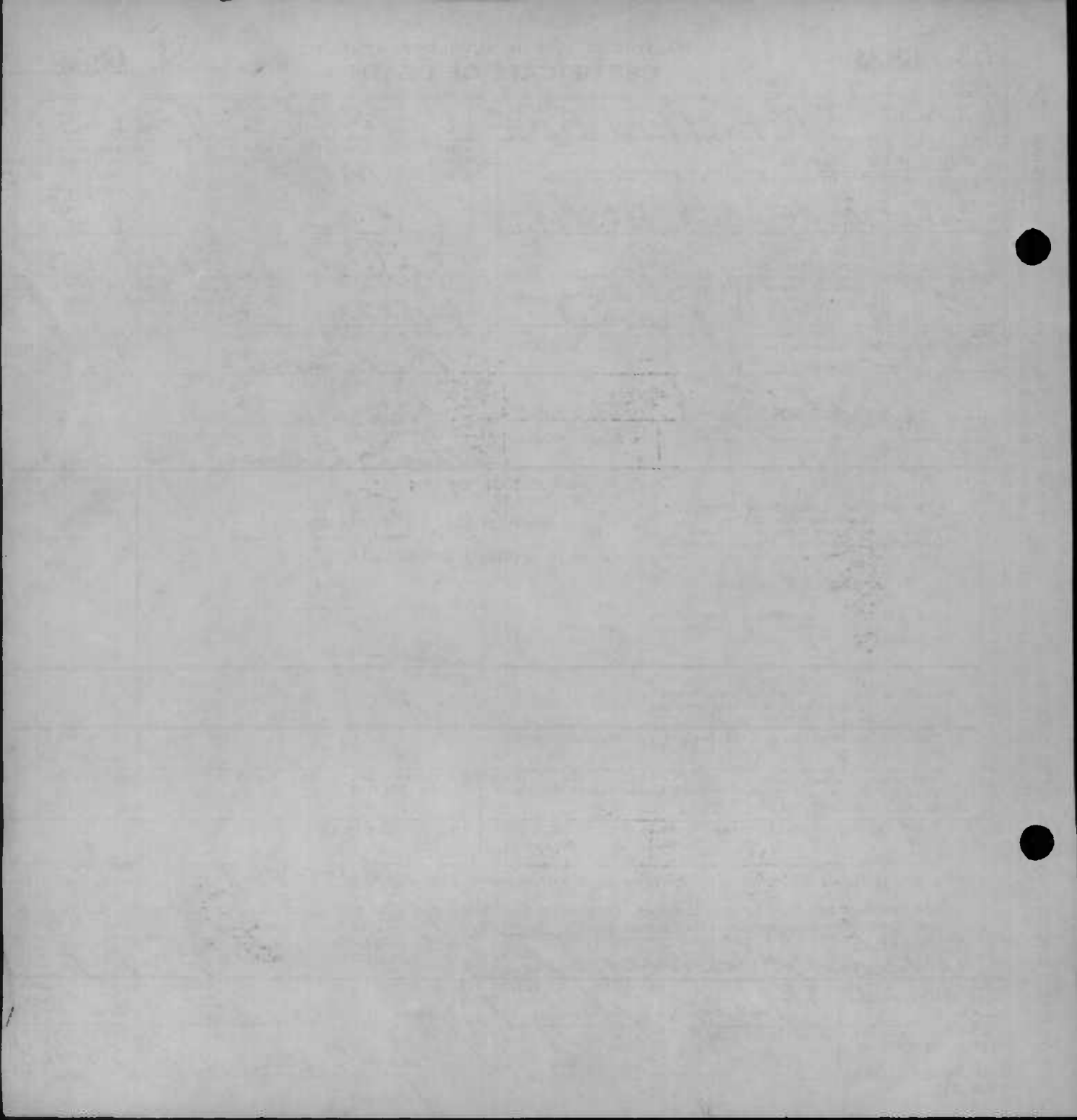
Huntington

25. FUNERAL DIRECTOR

Lilly & Zeiter

ADDRESS

4038 W. York





-600

6832

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6832

H. NO.

NAME OF DECEASED  
or Print)2. DATE  
OF  
DEATH

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
DECEASED (If not in hospital or institution, give street address or  
location)

INSTITUTION

Length of stay in Baltimore

X

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

14. MOTHER'S MAIDEN NAME

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

3.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

3 mos

5 yrs

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic pleuritis, lgs. pleuritis, etc.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 11, 1953 to July 25, 1953 that I last saw the  
deceased alive on July 11, 1953 and that death occurred at 6 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

BURIAL, CREMA-  
TION (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

E RECEIVED BY  
REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

29024



## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

53

6833

53-6833

NAME OF DECEASED  
(Last name or Print)

Denhard - Baby Boy

2. DATE  
OF  
DEATH

7-28-53

PLACE OF DEATH:

Baltimore City, Maryland

Mercy Hospital

FULL NAME OF  
(If not in hospital or institution, give street address or  
location)  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Balto

D. STREET ADDRESS (If rural, give location)

1527 Shady Side Rd

Length of stay in Baltimore

1 day 14 hrs

SEX

Male

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Infant

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

7-27-53

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.12. CITIZEN OF  
WHAT COUNTRY?A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mercy Hospital, Balto. Md

FATHER'S NAME

Elbert Denhard

14. MOTHER'S MAIDEN NAME

Genevieve Turney

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pre-maturity

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH1 day &  
14 hrs.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Delivered by breech presentation.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-27-53, 1953, to 7-28-53, 1953, that I last saw the  
deceased alive on 7-27-53, 1953, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Clara M. Santawana

23B. ADDRESS

Balto Mercy Hospital

23C. DATE SIGNED

7-28-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/28/53

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county) (State)

Wed Frederick Rd

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. J. Williams, M.D. J. J. Fahy &amp; Sons

25. FUNERAL DIRECTOR

ADDRESS

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Date of completion

14. Signature of medical examiner

15. Signature of coroner

16. Signature of jury

17. Signature of witnesses

18. Signature of funeral director

19. Signature of undertaker

20. Signature of others

250

6834

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6834

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>or Print) <i>Amanda J. Reagan</i>   |  | 2. DATE OF DEATH <i>July 25<sup>th</sup> '53</i>   |  |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>Baltimore</i>  |  |
| 5. PLACE OF DEATH (If not in hospital or institution, give street address or location)<br><i>Union Memorial Hospital</i>           |  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 13-07</i>   |  |
| 7. STREET ADDRESS (If rural, give location)<br><i>3606 Paine St.</i>   |  | 8. DATE OF BIRTH <i>Nov. 6, 23/1872</i>  |  |
| 9. AGE (In years, last birthday) <i>80 y</i>   |  | 10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |  |
| 11. BIRTHPLACE (State or foreign country) <i>Nanover Pa.</i>   |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |  |
| 13. MOTHER'S MAIDEN NAME <i>Lydia Utz</i>  |  | 14. INFORMANT ADDRESS <i>Hospital</i>  |  |
| 15. FATHER'S NAME <i>Artie Fuhrman (D)</i>   |  | 16. SOCIAL SECURITY NO. <i>-</i>   |  |
| 17. AS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>                                       |  | 18. CAUSE OF DEATH<br><i>260X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>(A) Hypertensive cardiovascular disease</i><br>DUE TO <i>disease</i><br><i>(B) Diabetes mellitus</i><br>DUE TO <i>Diabetes</i><br><i>(C) Diabetes mellitus</i> |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | 20. CERTIFICATION APPROVED BY<br><i>R. B. Fisher</i><br>CHIEF OR ASST. MEDICAL EXAMINER.   |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                |  | 22. INTERVAL BETWEEN ONSET AND DEATH   |  |
| 23. DATE OF OPERATION <i>7/28/53</i>   |  | 24. MAJOR FINDINGS OF OPERATION  |  |
| 25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 26. DATE OF OPERATION <i>7/28/53</i>   |  |
| 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 29. DATE OF DEATH (Month) (Day) (Year) <i>7/25/53</i>  |  | 30. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |
| 31. HOW DID INJURY OCCUR?  |  | 32. I hereby certify that I attended the deceased from <i>7/25/53</i> , 19 <i>53</i> , to <i>7/25/53</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7/25/53</i> , 19 <i>53</i> , and that death occurred at <i>10:15</i> am., from the causes and on the date stated above.   |  |
| 33. SIGNATURE <i>William T. Fisher</i>   |  | 34. ADDRESS <i>Union Memorial Hospital</i>   |  |
| 35. DATE <i>7/28/53</i>  |  | 36. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>   |  |
| 37. LOCATION (City, town, or county) <i>Balto. Md.</i>   |  | 38. STATE <i>Md.</i>   |  |
| 39. REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>   |  | 40. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook Inc. 1217 St. Paul St</i>   |  |





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

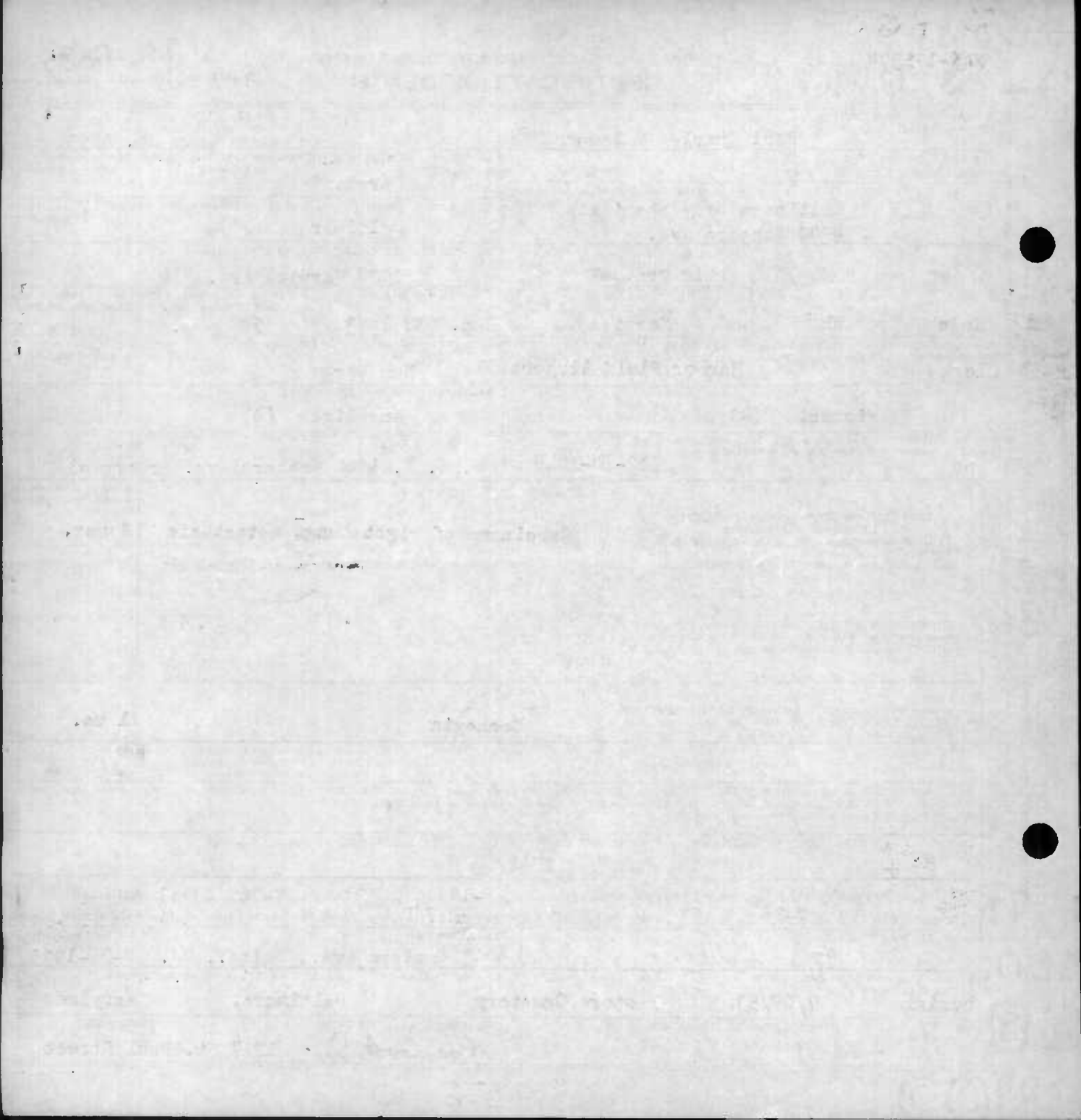
MAF-171374  
53 6835

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6835  
Registered No.

|  |                               |  |  |   |  |
|--|-------------------------------|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Paul Charles Salomone</b>   |                               |  | 2. DATE OF DEATH<br><b>July 26, 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b>   |                               |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>16-05</b>                  |   |  |
| c. Length of stay in Baltimore <b>12 yrs.</b><br>Yrs. Mos. Days  |                               |  | D. STREET ADDRESS (If rural, give location)<br><b>1008 Warwick Ave. #16</b>  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Wh</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>                                      | 8. DATE OF BIRTH<br><b>Dec. 25, 1893</b>   |   | 9. AGE (In years last birthday)<br><b>59</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Harbor Field Airport</b>                                       | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |   | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>Michael (d)</b>  |                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Angeline (d)</b>  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>   |                               | 16. SOCIAL SECURITY NO.<br><b>112-10-1849</b>  | 17. INFORMANT ADDRESS<br><b>B. C. H. 4940 Eastern Ave. (records)</b>   |   |  |
| 18. <b>167x I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of right Lung Metastasis</b><br>(A) DUE TO<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C) |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b>  |   |  |
| II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.<br><b>Cachexia</b>  |                               |  | 1 no.  |   |  |
| 19A. DATE OF OPERATION   |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-19</b> , 19 <b>53</b> to <b>7-26</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-26</b> , 19 <b>53</b> , and that death occurred at <b>7 P</b> m., from the causes and on the date stated above.   |                               |  |  |   |  |
| 23A. SIGNATURE<br><i>H. J. Salomone</i>  |                               |  | 23B. ADDRESS<br><b>4940 Eastern Ave., Balto., Md.</b>  |   | 23C. DATE SIGNED<br><b>7-26-1953</b>         |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                               | 24B. DATE<br><b>7/29/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |                               | 24E. FUNERAL DIRECTOR ADDRESS<br><b>Wm. Cook, Inc., 1217 St. Paul Street</b>                           |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 28 1953</b>   |                               | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Wm. Cook, Inc., 1217 St. Paul Street</b> |  |

39056



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

B-657

53 6836  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6836

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Charles Burns</b>  |                                  |   | 2. DATE OF DEATH <b>July 27, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>md.</b><br>B. COUNTY <b>BALTO.</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Towson</b>  |  |   |
| c. Length of stay in Baltimore<br>Yrs. <b>23</b><br>Mos. <b>53</b><br>Days <b>55</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1809 Abundeen Rd.</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>6-1-04</b>  | 9. AGE (in years last birthday)<br><b>49</b>   | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stenographer- recording</b>                    |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Court Records Office</b>   |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |
| 13. FATHER'S NAME<br><b>Charles T. Burns</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Loretta Bowen</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>                            |  | 17. INFORMANT<br><b>JOHNS HOPKINS HOSPITAL</b> |   |
| 18. <b>434.0</b>   |                                  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH               |   |

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial infarction, acute**  
DUE TO

**5 min.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Kyphoscoliotic heart disease**  
DUE TO

**20+ yrs**

(C) **Osteoarthritis imperfecta**  
DUE TO

**48+ yrs**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>7-26-53</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>7-26, 1953</b> , to <b>7-27, 1953</b> , that I last saw the deceased alive on <b>7-27, 1953</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>James C. Vandell Jr.</b>   |  |   |  | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                            |  | 23C. DATE SIGNED<br><b>7/27/53</b>  |  |

|  |   |   |  |
|--|---|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 30, 1953</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Towson, Maryland</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 28 1953</b>     | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>   |  |

VS 150

350 93

STATE OF TEXAS

County of Bexar

Know all men by these presents, that

I, the undersigned, for and in consideration of the sum of

Five hundred and no/100 Dollars

to me in hand paid by the said

County of Bexar, the receipt of which is hereby acknowledged,

have granted, sold and conveyed, and by these presents do

grant, sell and convey unto the said

County of Bexar, all that certain

tract of land containing

Five hundred and no/100 Acres

more or less, situated in

the County of Bexar, State of Texas,

together with all and singular

rights and appurtenances in anywise

in anywise in anywise in anywise

in anywise in anywise in anywise

in anywise in anywise in anywise

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6837

BIRTH NO. 53 6837 53-16494

1. NAME OF DECEASED (Type or Print) DAVID GILL CAMPBELL

2. DATE OF DEATH 7/27/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland / 4th

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD B. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

515 Walker Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

7/19/53

9. AGE (In years last birthday)

10 Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Babe

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William O. Campbell

14. MOTHER'S MAIDEN NAME

Elizabeth Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

William O. Campbell, 515 Walker Ave., Balto., Md.

ADDRESS

INTERVAL BETWEEN ONSET AND DEATH

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Peritonitis

Infection of Umbilical Cord

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY? YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 22, 1953 to June 27, 1953 that I last saw the deceased alive on June 26, 1953, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

July 30, 1953

24C. NAME OF CEMETERY OR CREMATORY

Oakes &amp; Nickels Funeral Home, Columbia, Tennessee

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

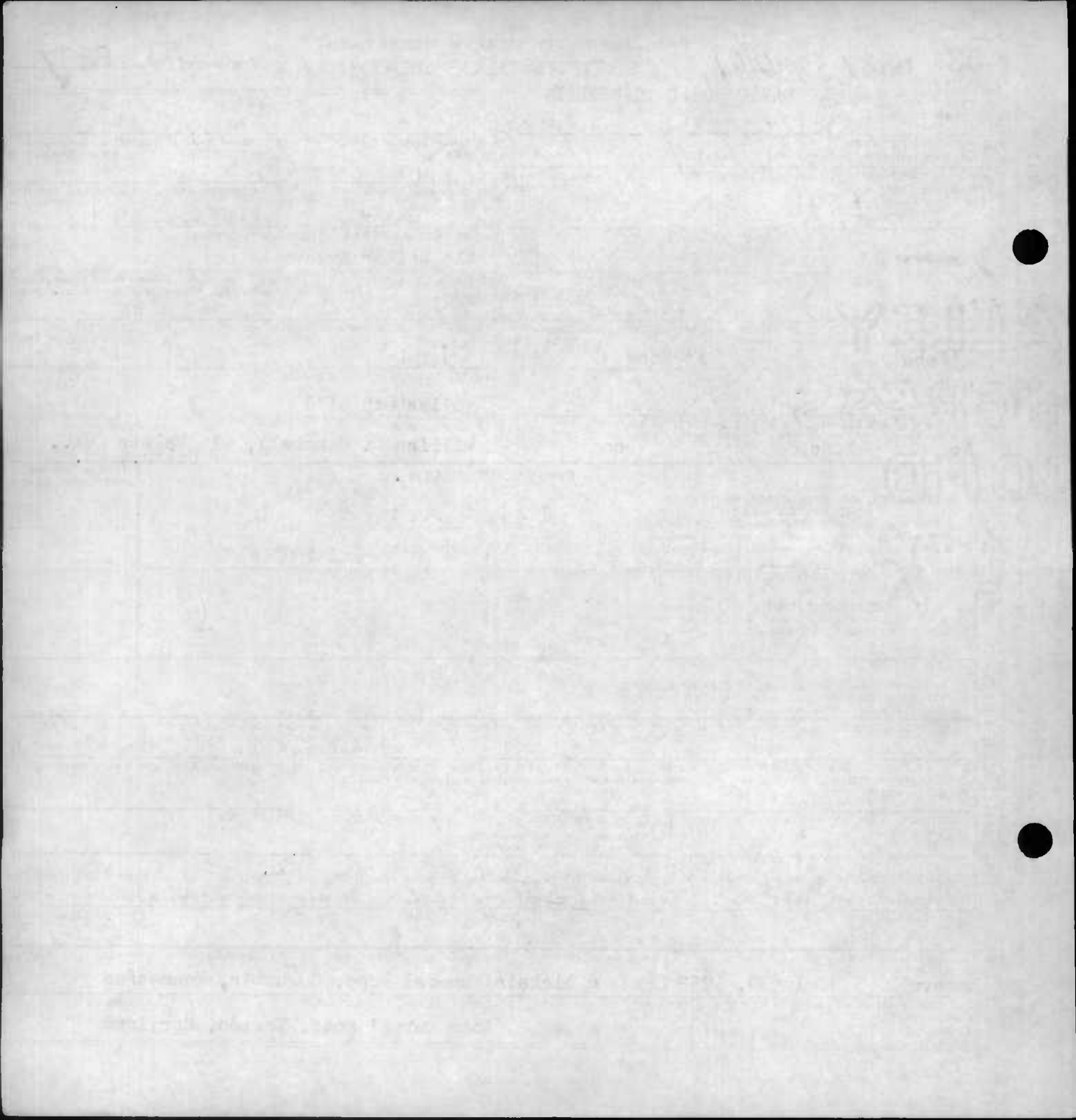
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John Burns' Sons, Towson, Maryland

VS 150





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6838**BIRTH NO. **53 6838**

|   |   |  |  |
|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN T. BAYNE</b>   |   | 2. DATE OF DEATH<br><b>7/27/53</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CO.</b> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)<br><b>UNIVERSITY HOSPITAL</b> |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>COCKEYSVILLE</b>  |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |   | D. STREET ADDRESS (If rural, give location)<br><b>HOWARDS FOREST</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>CAUCASIAN</b>                  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SEPARATED</b>  | 8. DATE OF BIRTH<br><b>1872</b>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Florist Assistant</b>           |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Florist</b>   | 9. AGE (In years last birthday)<br><b>81</b>                         |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>John Bayne</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah BaubRitz</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>UNKNOWN</b>   | (If Yes, give war or dates of service)<br><b>None</b> | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT ADDRESS<br><b>Mr. Charles A. Bayne, Baltimore, Md.</b> |

|  |                |                                  |
|--|----------------|----------------------------------|
| 18. <b>470.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCTION</b><br>DUE TO | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>ARTERIOSCLEROSIS</b><br>DUE TO  |                |                                  |

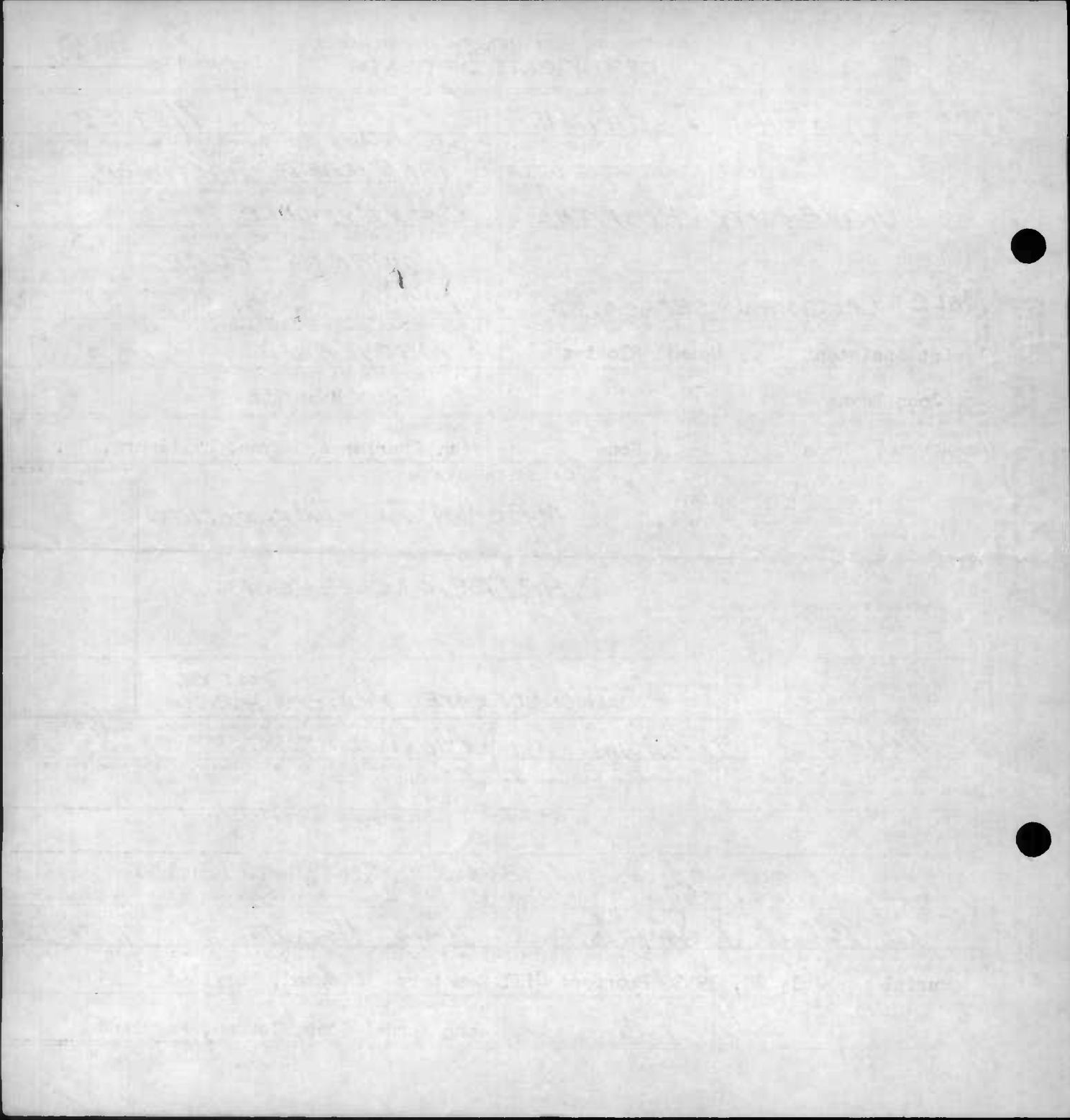
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Post. OP. INCARCERATED RICHTERS HERNIA**

|   |   |  |   |
|---|---|--|---|
| 19A. DATE OF OPERATION<br><b>7/4/53</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTESTINAL OBSTRUCTION</b>                         | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

22. I hereby certify that I attended the deceased from **July 4, 1953** to **July 27, 1953** that I last saw the deceased alive on **July 27, 1953** and that death occurred at **12:50** A.M., from the causes and on the date stated above.

23A. SIGNATURE **Robert J. Singletary** M. D. 23B. ADDRESS **Univ. Hospital** 23C. DATE SIGNED **7/27/53**

|  |   |   |  |
|--|---|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 29, 1953</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Towson, Maryland</b> |
| DATE RECEIVED BY LOCAL REGISTRAR                           | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>John Burns' Sons,</b>                    | ADDRESS<br><b>Towson, Maryland</b>                                       |



M-245  
MAF-172591

BALTIMORE CITY HEALTH DEPARTMENT

53 6839

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

53 6839

(SUSIE)

1. NAME OF DECEASED  
(Type or Print)

Susie McClain

2. DATE  
OF  
DEATH

July 26, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

868 Park Ave.

c. Length of stay in Baltimore

60 yrs.

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Mar. 17, 1861

9. AGE (In years  
last birthday)

92

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Issac McClain

14. MOTHER'S MAIDEN NAME

Catherine Freyberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. E 900.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cirrhosis Of Liver

DUE TO

(C)

CERTIFICATION APPROVED BY

Joseph A. Jachinsky  
M. D.  
ASSY. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONITION CAUSING IT.

Fracture of Left Hip

19A. DATE OF OPERATION  
July 24, 195319B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED  
Blount Plate - left hipIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)  
Home21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?  
868 Park Ave. 11-0321D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
July 21-195321E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒21F. HOW DID INJURY OCCUR?  
Slipped and  
Fell down stairs22. I hereby certify that I attended the deceased from 7-22, 1953, to 7-26, 1953, that I last saw the  
deceased alive on 7-26, 1953, and that death occurred at 5:30A m., from the causes and on the date stated above.

23A. SIGNATURE

H. Jachinsky

M. D.

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

7-26-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/29/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Irvington

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Jachinsky Co

ADDRESS

4800 Reisterstown Rd

VS 150

To Be Approved By Medical Examiner

J. Jachinsky &amp; Co.

Funeral Directors

N-870.0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6840BIRTH NO. 53 68401. NAME OF DECEASED  
(Type or Print)JOHN A DODD2. DATE  
OF  
DEATH7/25/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE B COUNTY 8 before admission)B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION1311 N. CAROLINE ST

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore City 8-07

D. STREET ADDRESS (If rural, give location)

1311 N. CAROLINE STc. Length of stay in Baltimore lifeYrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,

WIDOWED (Specify)

8. DATE OF BIRTH

1885

9. AGE (In years

67 last birthday)

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRYUpholsterer

11. BIRTHPLACE (State or foreign country)

Baltimore Md12. CITIZEN OF  
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

Thomas A Dodd

14. MOTHER'S MAIDEN NAME

Jeffer Shire Trusty15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bertha H. Mason 330 Cherryland Rd18. 420.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

ARTERIOSCLEROTIC HEART  
Disease

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. H. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER..... ☒ASSISTANT MEDICAL EXAMINER..... ☐

23C. DATE SIGNED

7-26-5324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

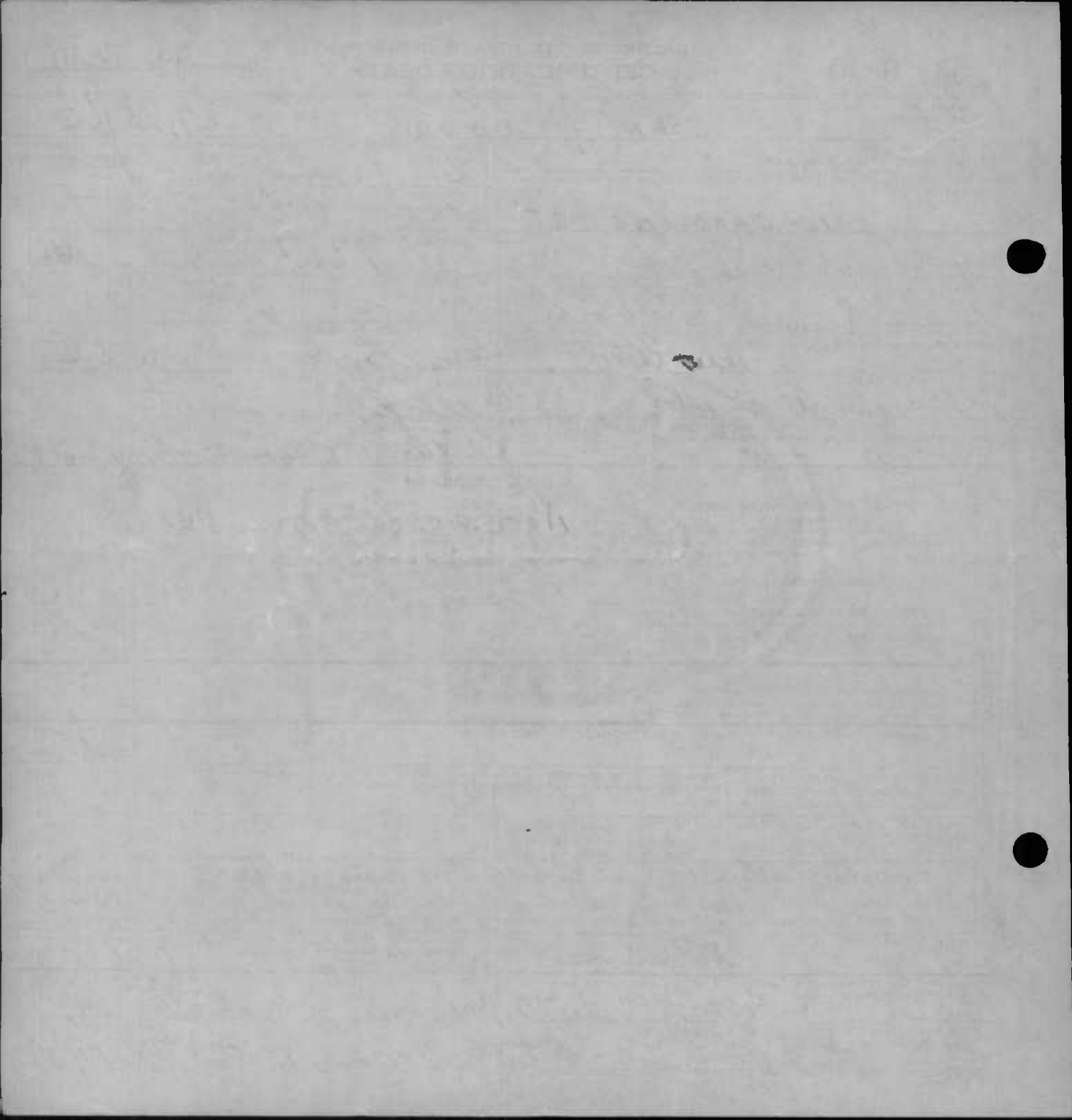
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial July 27 1953 Arbutus Memorial Park Baltimore MdJul 28 1953 Wilmington William Arthur Williams 1515 McElenny St





MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

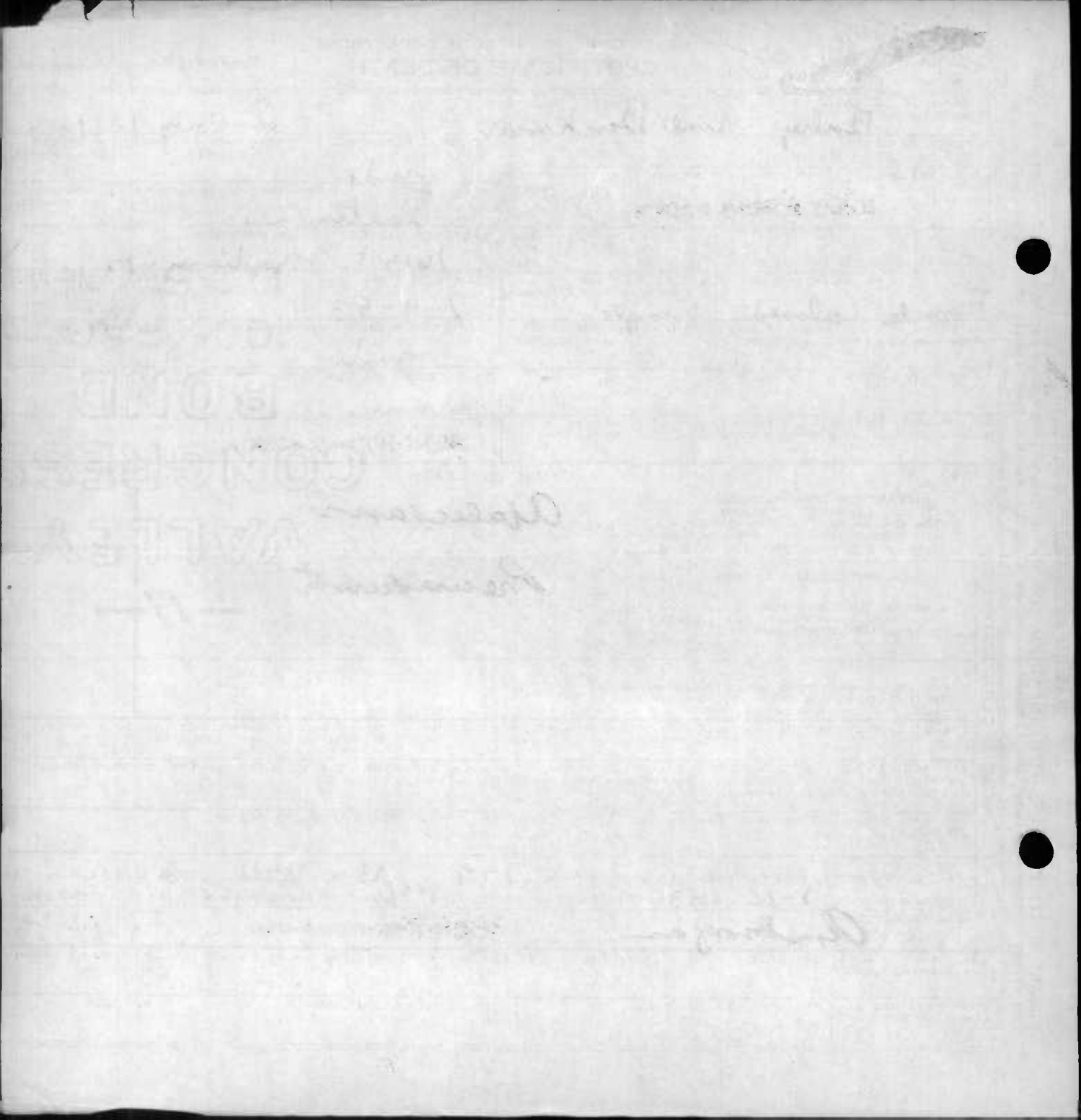
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6841

BIRTH NO. 53-21593

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Baby Mine Backman</u>  |                                 | 2. DATE OF DEATH <u>July 12, 1953</u>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u><br>B. COUNTY <u>md.</u> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>                                    |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 7-05</u>                                |  |
| c. Length of stay in Baltimore<br>Yrs. <u>0</u><br>Mos. <u>0</u><br>Days <u>0</u>                        |                                 | D. STREET ADDRESS (If rural, give location)<br><u>1613 E. Madison St.</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>  | 8. DATE OF BIRTH <u>7-9-53</u>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                 | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <u>3</u><br>If Under 1 Year: Months: <u>3</u> Days: <u>0</u><br>If Under 24 Hours: Hours: <u>0</u> Min. <u>0</u> |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>md.</u>  |  |
| 13. FATHER'S NAME <u>0</u>   |                                 | 14. MOTHER'S MAIDEN NAME <u>Annie</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                 | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>  |                                 | ADDRESS  |  |

|  |  |  |   |
|--|--|--|---|
| 18. <u>762.5</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Atelectasis</u><br>DUE TO                            |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Pneumonia</u><br>DUE TO   |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |   |
| 19A. DATE OF OPERATION <u>0</u>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>7-9</u> 19 <u>53</u> , to <u>7-12</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>53</u> , and that death occurred at <u>9:25</u> p.m., from the causes and on the date stated above. |  |  |   |
| 23A. SIGNATURE <u>Am Morgan</u>  | 23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>   | 23C. DATE SIGNED <u>7-14-53</u>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE  | 24C. NAME OF CEMETERY OR CREMATORY <u>Hopkins Disposal</u>               | 24D. LOCATION (City, town, or county) (State)                         |
| DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 20 1953</u>  | REGISTRAR'S SIGNATURE <u>Huntington Williams, Jr.</u>  | 25. FUNERAL DIRECTOR ADDRESS   |   |



## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 6842

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH.  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Prematurity  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19-1953 to 7-20-1953, that I last saw the  
deceased alive on 7-20-1953, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

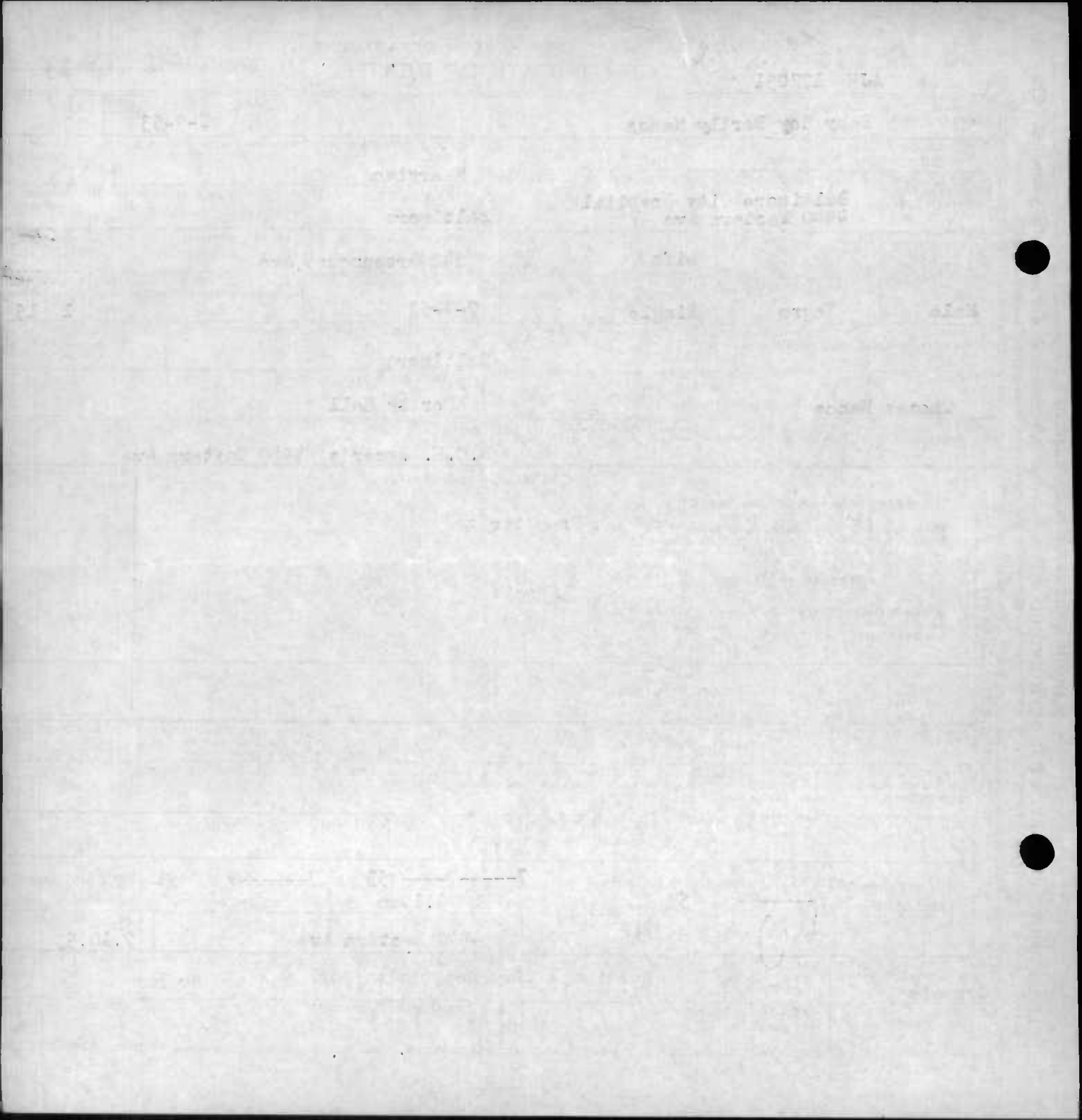
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



| Baltimore City Health Department   |                                  |   |   | Registered No. 53 6843   |                                 |
|--|----------------------------------|---|---|--|---------------------------------|
| BIRTH NO. 53 6843 53-15323 AJH 172051  |                                  |   |   |  |                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy Dorthy Nance</b>  |                                  |   |   | 2. DATE OF DEATH <b>7-9-53</b>   |                                 |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>10-02</b> |  |                                 |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Ave</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |                                 |
| c. Length of stay in Baltimore <b>Life</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>842 Greenmount Ave</b>  |  |                                 |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>7-9-53</b>   | 9. AGE (In years last birthday)<br><b>1</b>                              | 10. Under 24 Hours<br><b>15</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  | 12. CITIZEN OF WHAT COUNTRY?    |
| 13. FATHER'S NAME<br><b>Thomas Nance</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Dorthy Hall</b>  |  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>B.C.H. Records 4940 Eastern Ave</b>   |  |                                 |
| 18. <b>762.5</b> I CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Prematurity</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>(B) Anoxia</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br><b>(C) 5-6</b> |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |   |  |                                 |
| 19A. DATE OF OPERATION   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |                                 |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |  |                                 |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |                                 |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |                                 |
| 22. I hereby certify that I attended the deceased from <b>7-9-1953</b> , to <b>7-9-1953</b> , that I last saw the deceased alive on <b>7-9-1953</b> , and that death occurred at <b>4.10am.</b> , from the causes and on the date stated above.  |                                  |   |   |  |                                 |
| 23A. SIGNATURE<br><i>H. J. ...</i>   |                                  | 23B. ADDRESS<br><b>4940 Eastern Ave</b>   |   | 23C. DATE SIGNED<br><b>7.10.53</b>                                       |                                 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremated</b>   |                                  | 24B. DATE<br><b>716-1953</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore City Hospitals</b>    |                                 |
| 24D. LOCATION (City, town, or county) (State)<br><b>4940 Eastern Avenue</b>  |                                  |   |   |  |                                 |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>111 28 1953</b>   |                                  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams</i>   |   | 25. FUNERAL DIRECTOR ADDRESS   |                                 |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

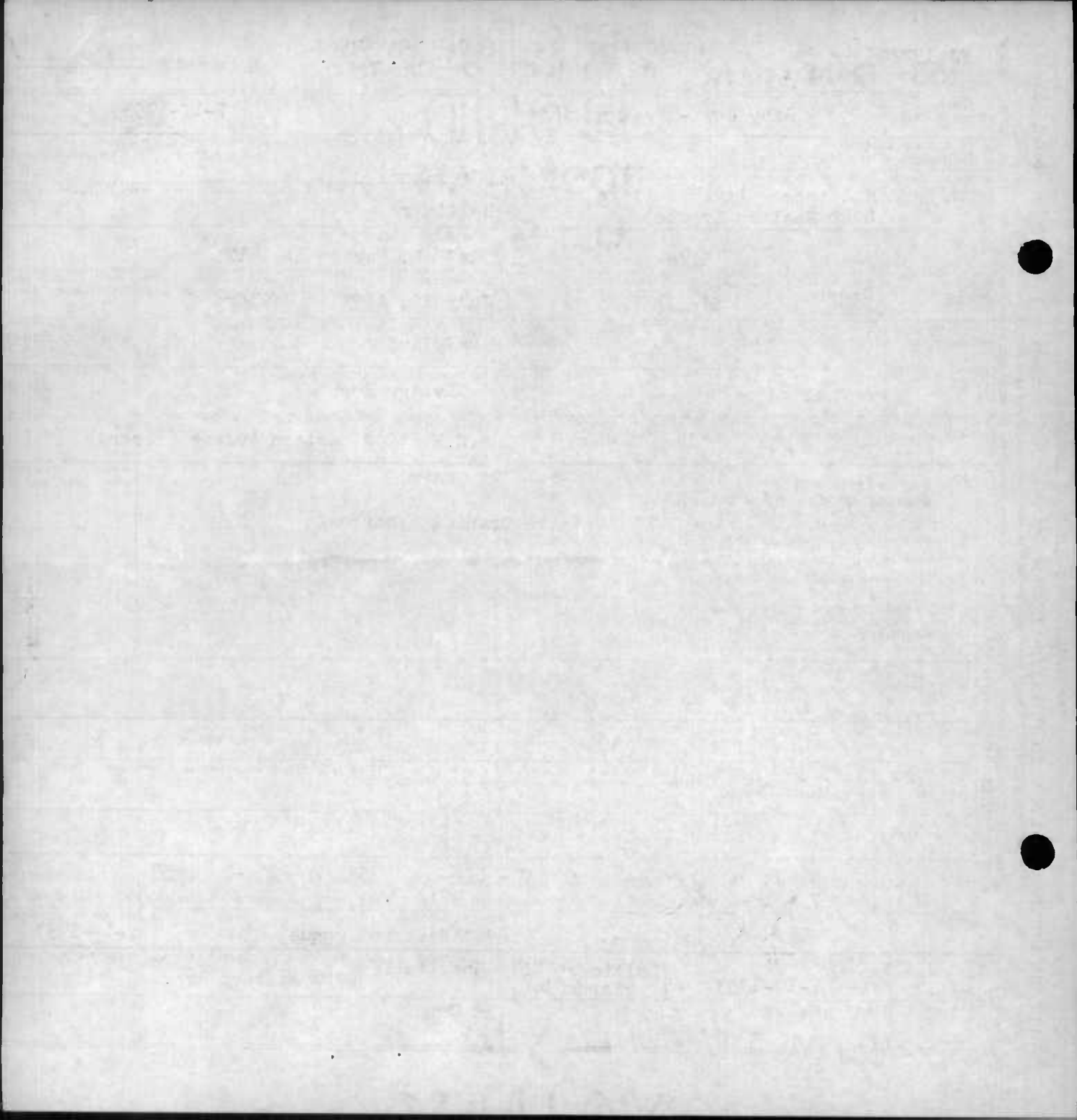
Registered No. 53 6844

FJ 122205  
BIRTH No. 53 6844 53-16198

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy - Evelyn Odoms</b>   |                                   | 2. DATE OF DEATH<br><b>7-12-1953</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>15-02</b> |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                   | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |   |
| 7. Length of stay in Baltimore <b>life</b>  |                                   | 8. STREET ADDRESS (If rural, give location)<br><b>1636 N. Payson St. #17</b>  |   |
| 9. SEX<br><b>Male</b>   | 10. COLOR OR RACE<br><b>Negro</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   | 12. DATE OF BIRTH<br><b>July 12, 1953</b> |
| 13. AGE (In years last birthday)<br><b>Newborn</b>  |                                   | 14. Under 1 Year Months: Days<br><b>4</b>   |   |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                   | 16. KIND OF BUSINESS OR INDUSTRY  |   |
| 17. FATHER'S NAME<br><b>Paul Odoms</b>  |                                   | 18. MOTHER'S MAIDEN NAME<br><b>Evelyn Buck</b>  |   |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                   | 20. SOCIAL SECURITY No.   |   |
| 21. INFORMANT<br><b>B.C.H. 4940 Eastern Avenue (record)</b>   |                                   | 22. ADDRESS   |   |

|  |  |   |
|--|--|---|
| 18. <b>760.5</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Intra Cranial Hemorrhage</b><br>DUE TO<br><b>(B) Anoxia</b><br>DUE TO<br><b>(C) 2-4 1/2</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |
| 21A. DATE OF OPERATION<br><b>2</b>   | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 21C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II |
| 21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21F. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |
| 21G. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21H. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21I. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from <b>7-12-1953</b> to <b>7-12-1953</b> , that I last saw the deceased alive on <b>7-12-1953</b> and that death occurred at <b>7:26 P.m.</b> , from the causes and on the date stated above.   |  |   |
| 23A. SIGNATURE<br><b>H. John Doe</b>   | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>   | 23C. DATE SIGNED<br><b>7-12-1953</b>  |

|  |   |  |   |
|--|---|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremated</b> | 24B. DATE<br><b>7-17-1953</b>                                 | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore City Hospital</b> | 24D. LOCATION (City, town, or county) (State)<br><b>4940 Eastern Ave.</b> |
| 25. DATE RECEIVED BY LOCAL REGISTRAR                         | 26. REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 27. FUNERAL DIRECTOR   | 28. ADDRESS   |
| <b>JUL 28 1953</b><br>VS 150                                 |   |  |   |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

53 6845

53-16191

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6845  
Registered No.

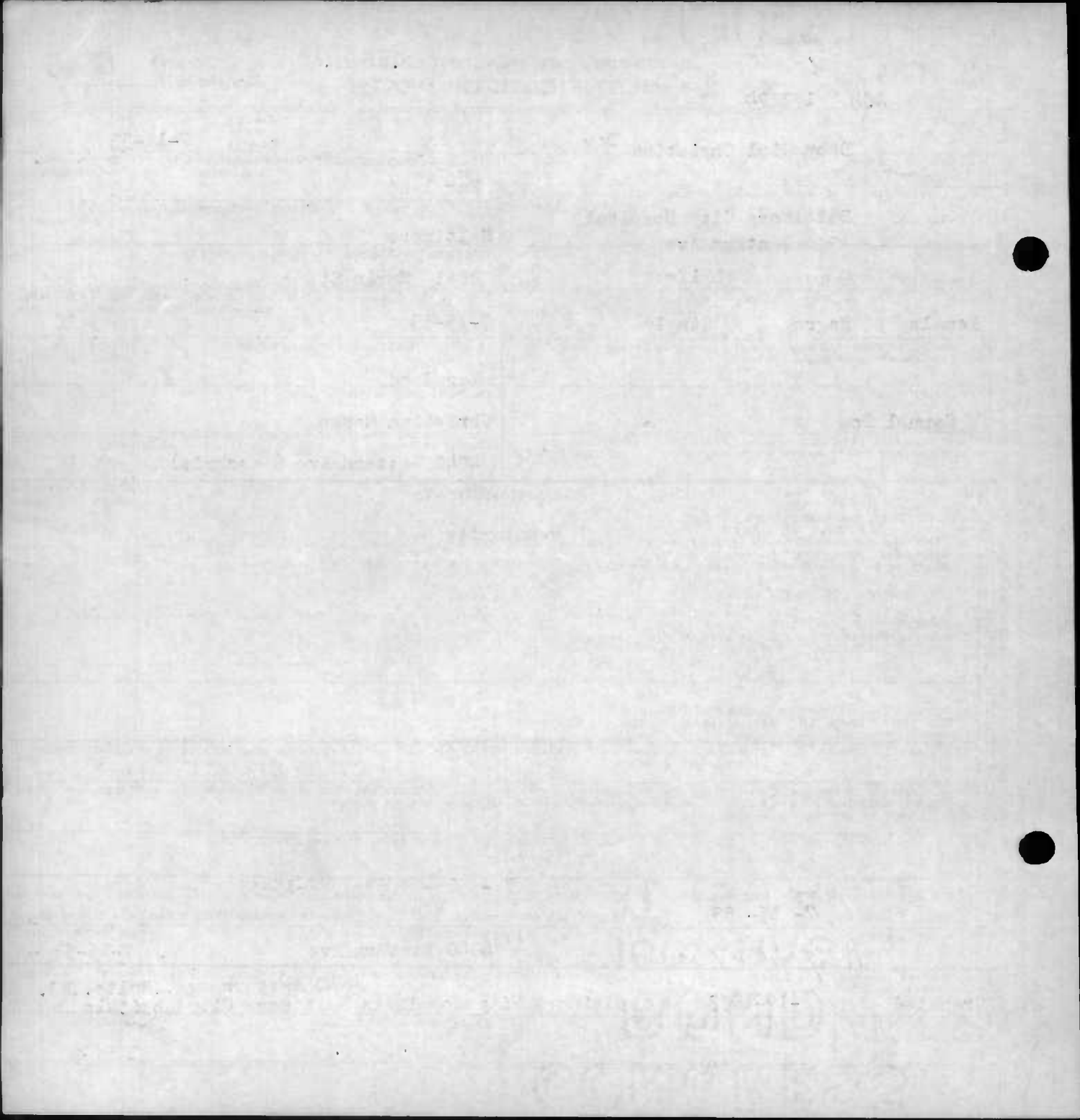
BIRTH NO. **Ajh 172294**

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Baby Girl Christina Dow</b>                                 |                                  | 2. DATE OF DEATH<br><b>7-15-53</b>  |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE<br><b>Maryland</b><br>B. COUNTY |                                    |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Ave</b>     |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                  |                                    |
| c. Length of stay in Baltimore <b>L ife</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2651 Huran St</b>   |                                    |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>7-15-53</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                  | 9. AGE (In years last birthday)<br><b>25-33</b>   |                                    |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                    |
| 13. FATHER'S NAME<br><b>Samuel Dow</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Christina Hough</b>  |                                    |
| 16. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT ADDRESS<br><b>4940 Eastern Ave (Records)</b>  |                                    |

|   |                           |                                  |
|---|---------------------------|----------------------------------|
| 18. <b>776x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>P rematurity</b><br>DUE TO | CAUSE OF DEATH            | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (B) DUE TO<br><b>2.12</b> |                                  |
| (C) DUE TO  |                           |                                  |

|  |   |  |   |
|--|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |   |
| 19A. DATE OF OPERATION<br><b>7-15-53</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7-15-53</b> , 19 <b>53</b> , to <b>7-15-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-15-53</b> , and that death occurred at <b>4 P</b> m., from the causes and on the date stated above. |   |  |   |
| 23A. SIGNATURE<br><b>H. J. Williams</b>  |   | 23B. ADDRESS<br><b>4940 Eastern Ave</b>                                  | 23C. DATE SIGNED<br><b>7-15-53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremated</b>   | 24B. DATE<br><b>7-17-1953</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore City Hospitals</b>    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore City Hospitals</b>    |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 28 1953</b>   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR ADDRESS   |   |

VS 150



1-425

3 6846

53 6846

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED  
(or Print)

Addie Wilkins

2. DATE  
OF  
DEATH

7/24/1953

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION1625 N. Appleton St  
Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1625 N. Appleton St.

Length of stay in Baltimore

SEX

female

6. COLOR OR RACE

Cot.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 1876

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Warsaw N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

FATHER'S NAME

David Williams

14. MOTHER'S MAIDEN NAME

Fannie

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mary Hill - N. Appleton St.

ADDRESS

18. CAUSE OF DEATH

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Chronic Cardio-renal  
Vascular disease

2-3 mos.

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. DATE (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1953 to July 24, 1953, that I last saw the  
deceased alive on July 24, 1953, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. L. Perry

23B. ADDRESS

M. D.

1420 E. Chase

23C. DATE SIGNED

July 27, 53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/28/1953

24C. NAME OF CEMETERY OR CREMATORY

Debutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams

ADDRESS

322 N. Schroeder St.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE



MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

M-250  
53 6847

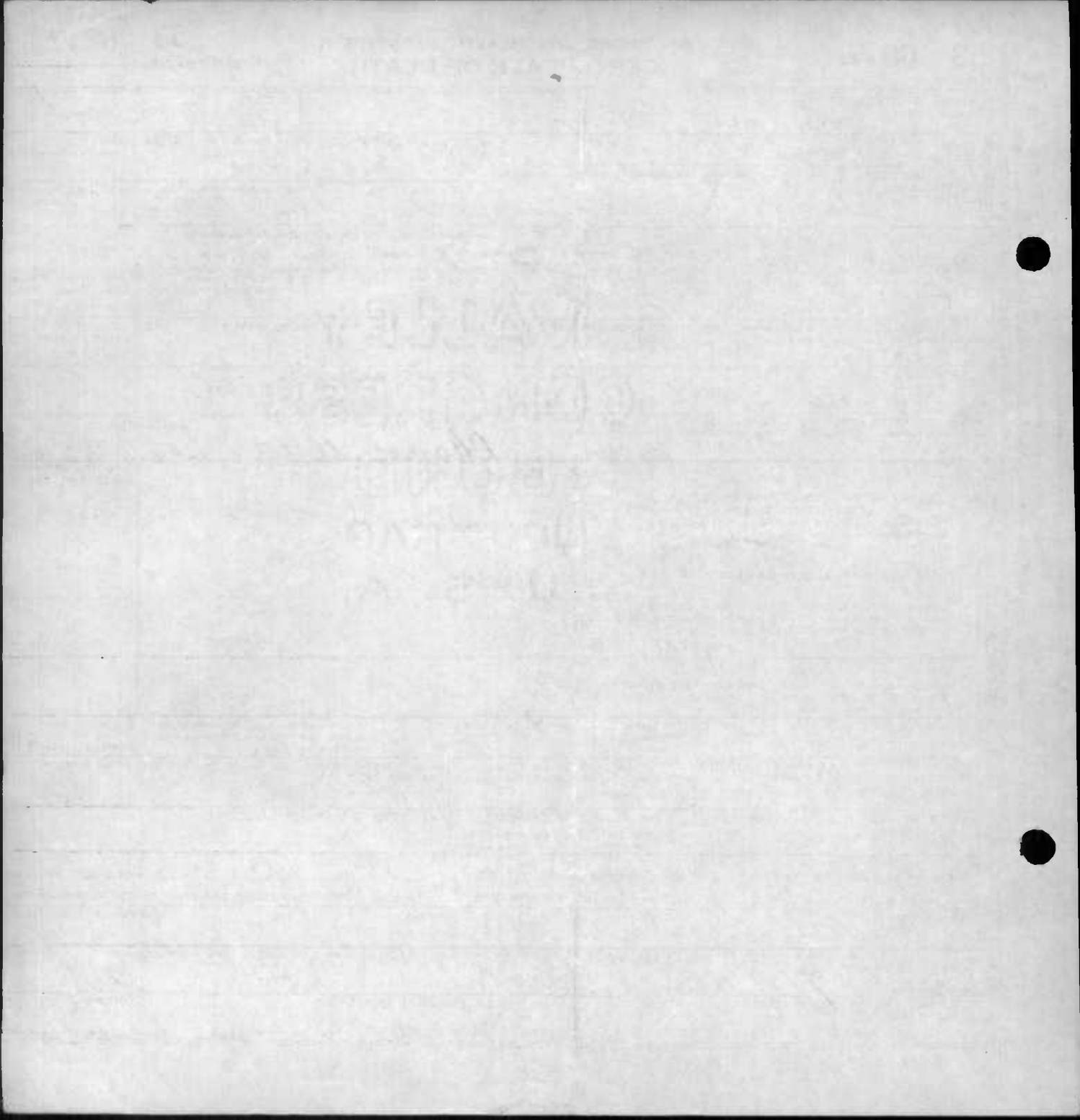
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6847  
Registered No.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Bernice Mason</i>  |  | 2. DATE OF DEATH<br><i>7/24/53</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>University Hospital</i>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 4-02</i>                       |  |
| c. Length of stay in Baltimore <i>Life - 38</i> Yrs. Mos. Days   |  | D. STREET ADDRESS (If rural, give location)<br><i>755 W. Mulberry St.</i>   |  |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>Negroe</i>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i>   | 8. DATE OF BIRTH<br><i>1915</i>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Domestic</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><i>38</i>   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Charles Allen</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Josephine Morrison</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><i>Charles Allen 606 N. Main St.</i>  |  | ADDRESS   |  |
| 18. <i>44xx</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br><i>Uremia + Congestive Heart Failure</i><br>DUE TO (A) .....<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <i>Nephrosclerosis</i><br>DUE TO (C) .....<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Anemia</i> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 Days</i>                                    |
| 19A. DATE OF OPERATION<br><i>0</i>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>m. <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21E. INJURY OCCURRED<br>21F. HOW DID INJURY OCCUR?                                       |   |  |
| 22. I hereby certify that I attended the deceased from <i>7/23</i> , 19 <i>53</i> , to <i>7/24</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>7/24</i> , 19 <i>53</i> , and that death occurred at <i>7:45 P.m.</i> , from the causes and on the date stated above.   |  |   |  |
| 23A. SIGNATURE<br><i>Herbert A. Bell</i> M.D.  |  | 23B. ADDRESS<br><i>University Hosp.</i>   | 23C. DATE SIGNED<br><i>7/24/53</i>   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 24B. DATE<br><i>7/29/53</i>  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>St. Johns Cem</i>  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>                   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>8</i>   |  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   | 25. FUNERAL DIRECTOR<br><i>Mrs. Kate R. Williams</i> ADDRESS <i>322 N. Schroeder</i> |

VS 150

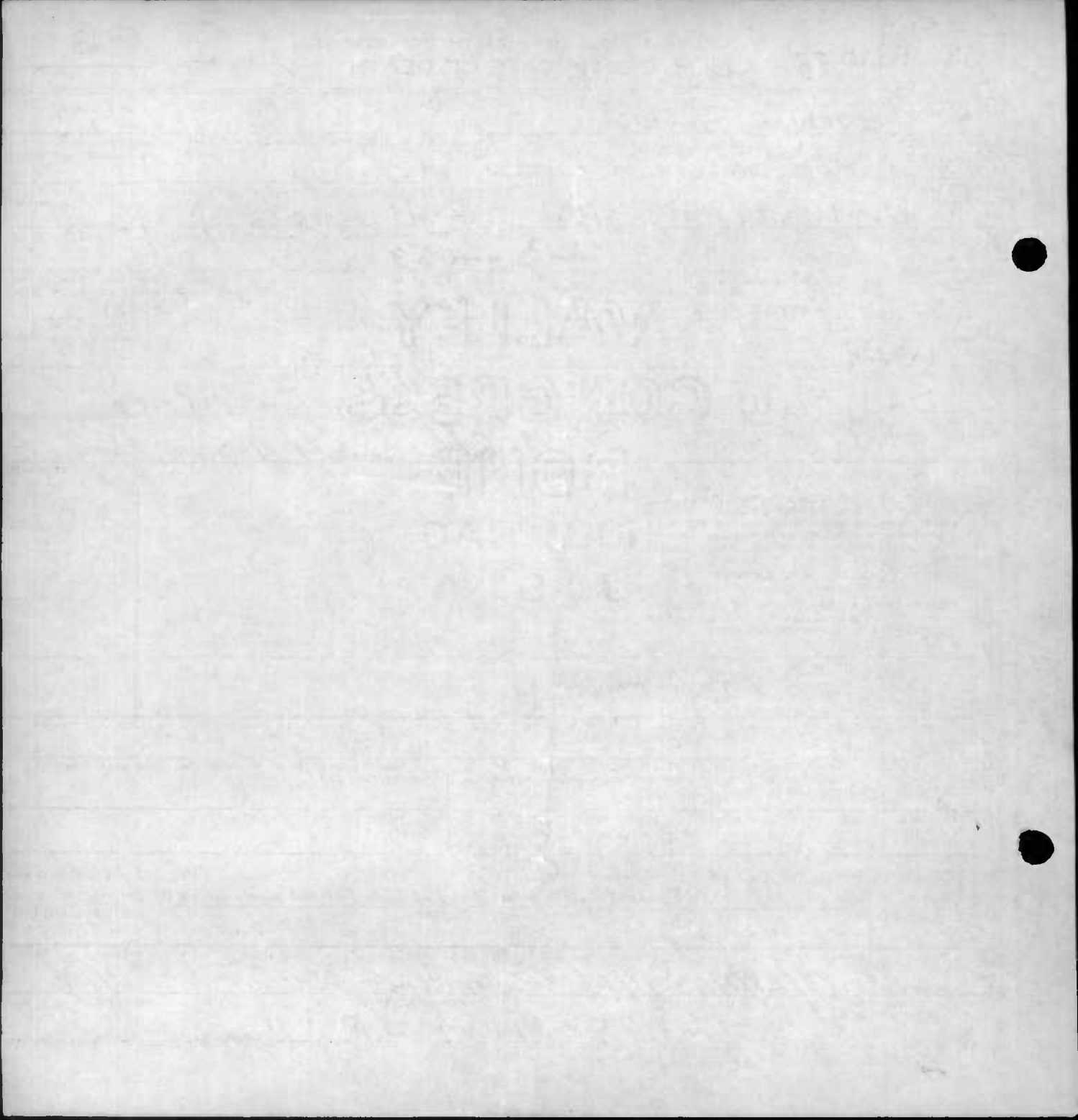
7208A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

|   |                           |  |                                |  |  |
|---|---------------------------|--|--------------------------------|--|--|
| S-540   |                           | BALTIMORE CITY HEALTH DEPARTMENT   |                                | 53 6848  |  |
| 53 6848   |                           | 53-16005   |                                | CERTIFICATE OF DEATH   |  |
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print) Evelyn Small  |                                | 2. DATE OF DEATH<br>7/25/53  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY B |                                |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br>28 University Hospital   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 18-02                        |                                |  |  |
| c. Length of stay in Baltimore  |                           | D. STREET ADDRESS (If rural, give location)<br>1033 W. Clay St.  |                                |  |  |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single  | 8. DATE OF BIRTH<br>May 1 1953 | 9. AGE (In years last birthday)<br>2                                     | 10. Under 1 Year<br>Months: Days<br>2 25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Infant   |                           | 10B. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country)<br>Baltimore                   |  |
| 13. FATHER'S NAME<br>12 Small   |                           | 14. MOTHER'S MAIDEN NAME<br>Ruth Small (Price)   |                                | 12. CITIZEN OF WHAT COUNTRY?<br>US                                       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.  |                                | 17. INFORMANT<br>Ruth Small 7033 W. Clay St.                             |  |
| 18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                 |                           | CAUSE OF DEATH<br>(A) diarrhea DUE TO  |                                | INTERVAL BETWEEN ONSET AND DEATH<br>3 days                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                           | (B) DUE TO   |                                |  |  |
| (C) DUE TO  |                           |  |                                |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                           |  |                                |  |  |
| 19A. DATE OF OPERATION  |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |                                | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |                                | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7-25, 1953, to 7-25, 1953, that I last saw the deceased alive on 7-25, 1953, and that death occurred at 1:15 P.M., from the causes and on the date stated above. |                           |  |                                |  |  |
| 23A. SIGNATURE<br>W. Heimer   |                           | 23B. ADDRESS<br>University Hosp.   |                                | 23C. DATE SIGNED<br>7-26-53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 24B. DATE<br>7/28/1953   |                                | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                    |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.  |                           | 24E. FUNERAL DIRECTOR<br>Mrs. Katie R. Williams  |                                | 24F. ADDRESS<br>322 N. Schroeder St.                                     |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 28 1953   |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams   |                                | 25. FUNERAL DIRECTOR<br>Mrs. Katie R. Williams                           |  |
| VS 150  |                           |  |                                |  |  |



7-452.  
53 6849

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6849  
Registered No.

|  |                            |  |  |
|--|----------------------------|--|--|
| 1. NAME OF DECEASED<br>(or Print) <b>Mielnick, Henrietta Margaret</b>  |                            | 2. DATE OF DEATH <b>July 27, 1953</b>  |  |
| 3. PLACE OF DEATH: <b>Baltimore City, Maryland</b>   |                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>St. Joseph's</b> |                            | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| 6. LENGTH OF STAY IN BALTIMORE   |                            | D. STREET ADDRESS (If rural, give location)<br><b>622 S. Ellwood Avenue</b>  |  |
| 7. SEX <b>M</b>  | 6. COLOR OR RACE <b>W.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>Jan. 11, 1903</b>   |
| 9. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Wife.</b>                 |                            | 10. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 9. AGE (In years last birthday) <b>50</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 11. FATHER'S NAME<br><b>Henry Bauers</b>   |                            | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Maryland</b>   |  |
| 12. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>                     |                            | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. 16. SOCIAL SECURITY NO.  |                            | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Biggerman</b>  |  |
| 15. 17. INFORMANT<br><b>Mrs. Fronie Berkerridge</b>  |                            | 18. ADDRESS<br><b>622 S. Ellwood Ave</b>   |  |

|  |  |                                  |
|--|--|----------------------------------|
| 19. CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebrovascular accident</b><br>DUE TO<br>(A) ..... |  |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertensive cardiovascular disease</b><br>DUE TO<br>(B) .....  |  |                                  |
| (C) .....  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 9A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)<br>OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from July 26, 1953 to July 27, 1953 that I last saw the deceased alive on July 27, 1953, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 23A. SIGNATURE<br><b>Carlos Forno P</b>                            |  | 23B. ADDRESS<br>M. D. <b>1100 N. Caroline Street</b>        |  | 23C. DATE SIGNED<br><b>July 27, 1953</b>                          |  |
| 24A. BURIAL, CREMATION, OR REMOVAL (Specify)<br><b>Burial</b>      |  | 24B. DATE<br><b>Aug. 1, 1953</b>                            |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b> |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore Maryland</b> |  | 25. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc.</b> |  | ADDRESS<br><b>Baltimore Md.</b>                                   |  |
| 26. RECEIVED BY<br>LOCAL REGISTRAR                                 |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 27. VS 150  |  |

*Seaf. T. Sander*

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED

Blank form with horizontal lines for text entry.



H-160  
53 6850

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6850  
Registered No.

|  |  |  |   |
|--|--|--|---|
| 1. NAME OF DECEASED (or Print)<br><b>William Marriot Haver</b>   |  | 2. DATE OF DEATH<br><b>July 26, 1953</b>   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Ardliegh Nursing Home</b><br><b>2075 Rockrose Ave.</b>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>9-06</b>                   |   |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>33</b> Yrs. <b>Mo.</b> <b>Do.</b>   |  | D. STREET ADDRESS (If rural, give location)<br><b>2728 Tivoly Ave.</b>   |   |
| 7. COLOR OR RACE<br><b>W</b>   | 8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Divorced</b> | 9. DATE OF BIRTH<br><b>Dec. 5, 1866</b>  | 10. AGE (In years last birthday)<br><b>86</b> |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Al Pier Supt.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Haver</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Marriot</b>  |   |
| 15. AS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705-09-6548</b>  |   |
| 17. INFORMANT<br><b>Mrs. Wm. D. G. Wrightson</b>   |  | ADDRESS  |   |
| 18. CAUSE OF DEATH <b>2511 Strathmore Ave</b><br><b>I</b><br><b>177x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Carcinoma of prostate with</b><br><b>Generalized Metastasis</b><br>DUE TO<br><b>(B)</b><br>DUE TO<br><b>(C)</b> |  |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Cardiac failure - Generalized Atherosclerosis</b>   |  |  |   |
| 20. DATE OF OPERATION<br><b>0</b>  |  | 21. MAJOR FINDINGS OF OPERATION<br><b>Chronic</b>  |   |
| 22. DATE OF OPERATION (Month) (Day) (Year) (Hour)<br><b>0</b>  |  | 23. DATE OF OPERATION (Month) (Day) (Year) (Hour)<br><b>0</b>  |   |
| 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 27. HOW DID INJURY OCCUR?  |   |
| 28. I hereby certify that I attended the deceased from <b>JAN</b> , 19 <b>53</b> , to <b>July 26</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 26</b> , 19 <b>53</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.  |  |  |   |
| 29. SIGNATURE<br><b>Carlton Brunsford</b>  |  | 30. ADDRESS<br><b>422 Mulick Ave Building</b>  |   |
| 31. DATE<br><b>July 29, 1953</b>   |  | 32. DATE SIGNED<br><b>7-27-53</b>  |   |
| 33. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem,</b>   |  | 34. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>   |   |
| 35. REGISTRAR'S SIGNATURE<br><b>Huntington</b>   |  | 36. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc.</b>  |   |
| 37. ADDRESS<br><b>Baltimore Md.</b>  |  | 38. ADDRESS<br><b>Baltimore Md.</b>  |   |

VS 150  
Sigs. F. Sander.

0000

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PROPERTY

DEBTS

TESTAMENTS

WILLS

EXECUTORS

ADMINISTRATORS

GUARDIANS

TRUSTEES

RECEIPTS

DISBURSMENTS

ACCOUNTS

FINANCIAL STATEMENTS

TAX RETURNS

LEGAL OPINIONS

COURT DECISIONS

SETTLEMENTS

RECEIPTS

DISBURSMENTS

ACCOUNTS

FINANCIAL STATEMENTS

TAX RETURNS

LEGAL OPINIONS

COURT DECISIONS

SETTLEMENTS

RECEIPTS

DISBURSMENTS

ACCOUNTS

FINANCIAL STATEMENTS

TAX RETURNS

LEGAL OPINIONS

COURT DECISIONS

SETTLEMENTS

RECEIPTS

DISBURSMENTS

ACCOUNTS

FINANCIAL STATEMENTS

F-140  
53 6851BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 68  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LENORE BEATRICE FOWBLE

2. DATE  
OF  
DEATH

7-27-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Hospital for Women of Maryland

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Fe

6. COLOR OR RACE

Wh.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

Balto.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Reisterstown

D. STREET ADDRESS (If rural, give location)

Hanover Road

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Canoe Co. Ind

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Milton Barrick

14. MOTHER'S MAIDEN NAME

Mabbitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Albert Fowble

ADDRESS

Reisterstown

18. 443 x 2 260 x

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Central Vascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Hypertensive arteriosclerosis  
Cardiovascular disease.

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1953, to 7/27, 1953, that I last saw the  
deceased alive on 7/27, 1953, and that death occurred at 12:54 p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. Deegan

23B. ADDRESS

Hosp. for Women of Md.

23C. DATE SIGNED

7/27/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 30 1953

24C. NAME OF CEMETERY OR CREMATORY

St Paul's Cemetery

24D. LOCATION (City, town, or county)

Arcadia

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

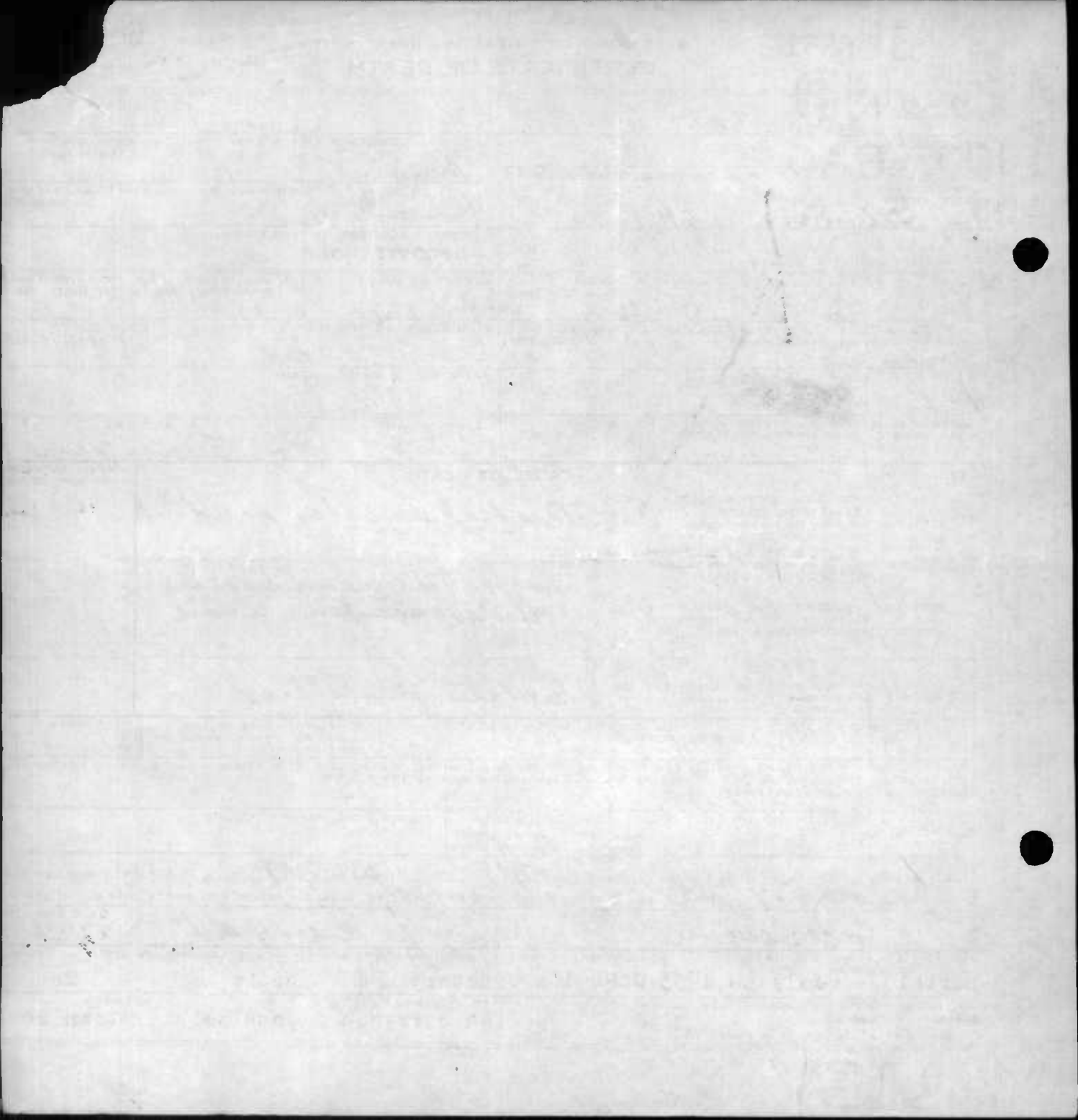
Wm Berryman &amp; Sons Reisterstown Md

ADDRESS

JUL 28 1953  
VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



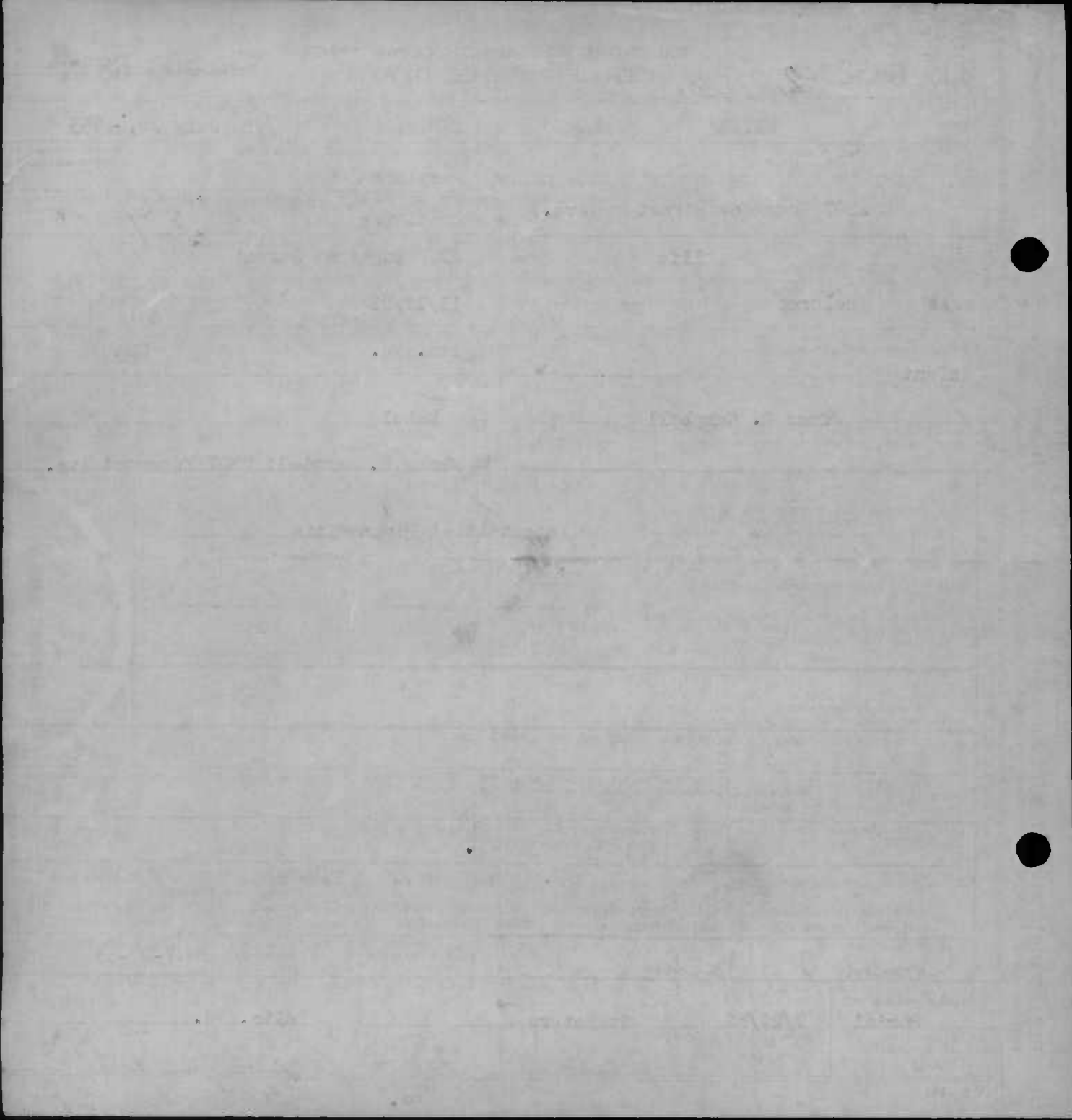
## BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 6852

BIRTH NO. 53 6852 52,27538. CERTIFICATE OF DEATH

|  |                                    |   |  |   |
|--|------------------------------------|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WAYNE ALONZO CAMPBELL</b>  |                                    |   | 2. DATE OF DEATH<br><b>July 26, 1953</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2307 Edgemont Street (Ave.)</b>                                   |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |   |
| C. Length of stay in Baltimore <b>life</b>   |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>2307 Edgemont Street</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><b>11/17/53</b>  | 9. AGE (In years last birthday)<br><b>8</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b> |                                    | 10B. KIND OF BUSINESS OR INDUSTRY               | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |   |
| 13. FATHER'S NAME<br><b>James R. Campbell</b>  |                                    |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)     |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Mabel</b>   |   |
| 16. SOCIAL SECURITY NO.  |                                    |   | 17. INFORMANT<br><b>James R. Campbell 2307 Edgemont Ave.</b>   |   |

|   |   |   |   |   |
|---|---|---|---|---|
| 18. <b>492X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Interstitial Pneumonitis</b><br>DUE TO   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO<br><b>(C)</b>  |   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |   |   |
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |   |   |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b>   |   | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....          |   | 23C. DATE SIGNED<br><b>7-27-53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE   | 24C. NAME OF CEMETERY OR CREMATORY  | 24D. LOCATION (City, town, or county) (State) |   |
| <b>Burial</b>   | <b>7/29/53</b>  | <b>St. Peters</b>   | <b>Balto. Md.</b>                             |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 28 1953</b>  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Rev. A. Nelson</b>   |   | ADDRESS<br><b>1303</b>  |





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6853  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES BRADFORD

2. DATE  
OF  
DEATH

7/24/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

a. STATE

b. COUNTY

before admission)

b. FULL NAME OF (If not in hospital or institution, give street address or location)

So. Balto. GEN. Hosp.

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. Md. 22-01

d. STREET ADDRESS (If rural, give location)

6 W. Montgomery St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

11-1900

9. AGE (In years

last birthday)

52

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Labor

11. BIRTHPLACE (State or foreign country)

Balto. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Bill Bradford

14. MOTHER'S MAIDEN NAME

Janie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

216-03-104

17. INFORMANT

ADDRESS

Mary Williams 624 George St.

18. E983X and 322.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion of brain

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute alcoholism

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Tavern

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

612 Charles Street

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

7/24/53

10:55

P. m.

21e. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

Blunt impact to head

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23a. SIGNATURE

P. B. Fisher M.D.

23b. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED

7/25/53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

7-30-53

24c. NAME OF CEMETERY OR CREMATORY

Mt. Lehigh Cemetery

24d. LOCATION (City, town, or county)

Balto.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

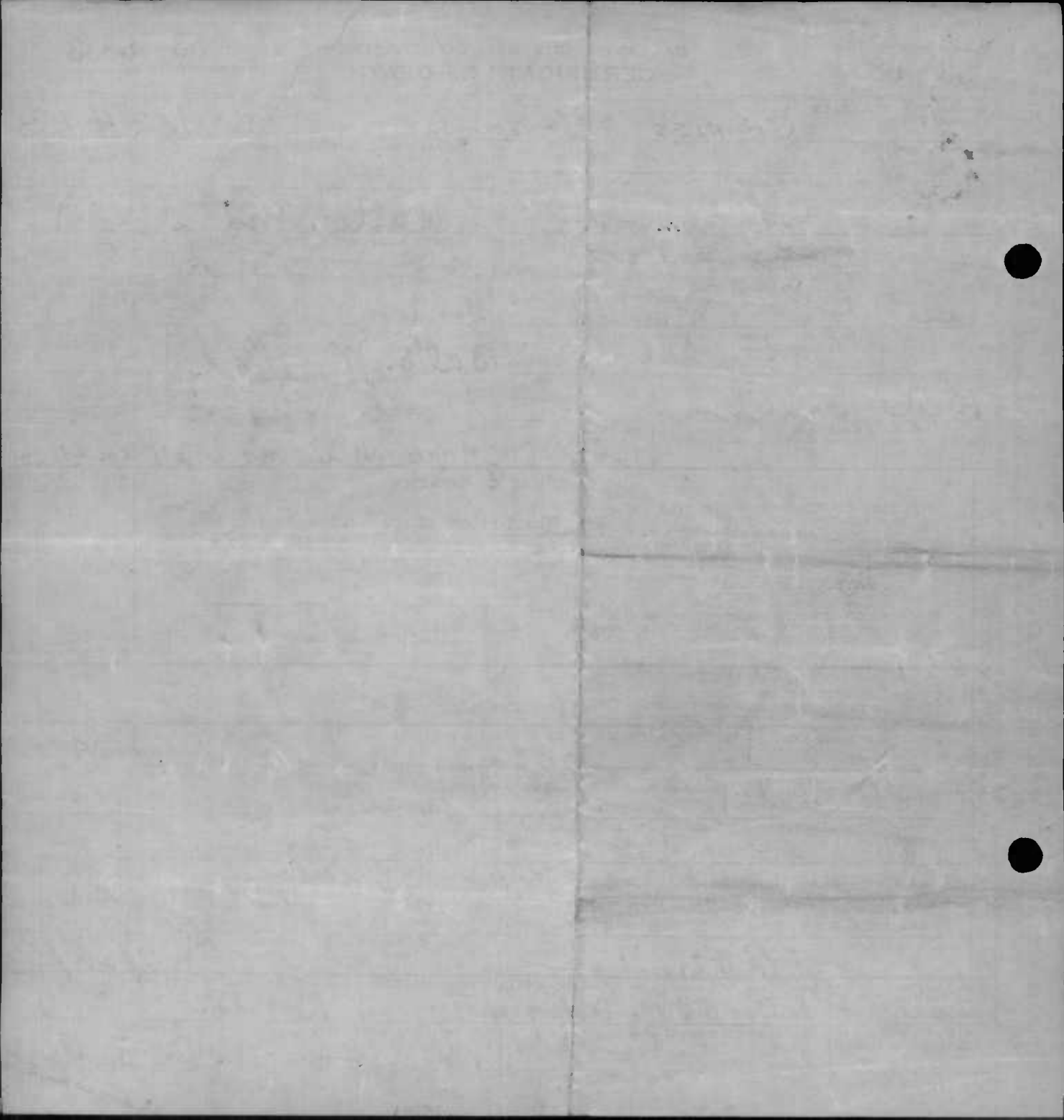
W. B. Spriggs 139 W. Hamilton St.

ADDRESS

VS 151

N 853.2

97099



H-450  
53 6854BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6854

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mr. Charles H. Heline

2. DATE  
OF  
DEATH

July 27, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5016 Catalpha Road

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5016 Catalpha Road

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept 17 1891

9. AGE (In years  
last birthday)

61

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Produce Buyer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry J. Heline

14. MOTHER'S MAIDEN NAME

Anna Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
212-01-4529

17. INFORMANT

ADDRESS

Mrs. Lillian G. Heline, 5016 Catalpha

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Coronary Occlusion

Immediate

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....Hypertensive Cardio-  
Vascular disease

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II20. AUTOPSY?  
YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1953, to July 27, 1953, that I last saw the  
deceased alive on July 25, 1953, and that death occurred at 8 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 1953

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road.

15-50-20

15-50-20

300

6855

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6855

Registered No.

H NO.

NAME OF DECEASED  
(or Print)

Suit, Mrs. Daisy Walton

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:

Baltimore City, Maryland St. Joseph's Hospital

FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore City, Md. 27-03

D. STREET ADDRESS (If rural, give location)

2404 Halcyon Ave.,

Length of stay in Baltimore

Yrs.  
Mos.  
Days

X 6. COLOR OR RACE

e. White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

FATHER'S NAME

Thomas W. Webster (Tillinghast)

14. MOTHER'S MAIDEN NAME

Linda Walton

HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No or unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 5604  
Mr. Howard F. Suit - Woodmont

B. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombus

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis (generalized)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Diabetes Mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

2. I hereby certify that I attended the deceased from July 24, 1953, to July 26, 1953 that I last saw the deceased alive on July 26, 1953, and that death occurred at 9:20 P.m. from the causes and on the date stated above.

3A. SIGNATURE

R. Cassinelli

M. D.

23B. ADDRESS

St. Joseph's Hospital

23C. DATE SIGNED

July 26

BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

STATE OF NEW YORK  
CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.



F-640  
\$-363  
TO BE APPROVED BY  
MEDICAL EXAMINERBALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6856

BIRTH NO. 53 6856

|  |                              |   |  |  |  |
|--|------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES FARRELL</b> (also known as <b>Milton Strode</b> )                            |                              |   | 2. DATE OF DEATH <b>July 23, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b><br><b>Wyman Pk. Drive &amp; 31st street</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>2-03</b>                   |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1627 Thames street</b>   |                              |   | E. Length of stay in Baltimore <b>?</b>  |  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b> | 8. DATE OF BIRTH<br><b>7/12/89</b>   |  | 9. AGE (In years last birthday)<br><b>64</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>                   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>seaman</b>                | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Anxious Farrell</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Shaver</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>?</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>218-01-0225</b>                     | 17. INFORMANT ADDRESS<br><b>Records- US PHS Hospital, Balto, Md.</b>   |  |  |

|   |   |              |                                  |
|---|---|--------------|----------------------------------|
| 18. <b>E 903.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH                                      |              | INTERVAL BETWEEN ONSET AND DEATH |
|   | (A) <b>Bronchopneumonia, terminal</b>               |              | <b>Short (recent)</b>            |
|   | DUE TO <b>Arteriosclerosis, marked, generalized</b> |              | <b>old</b>                       |
|   | (B) <b>Arteriosclerotic heart</b>                   |              | <b>old</b>                       |
| DUE TO <b>Nephrosclerosis</b>   |   | <b>old</b>   |                                  |
| (C) <b>Encephalomalacia</b>   |   | <b>old</b>   |                                  |
| <b>Fracture, neck of femur</b>  |   | <b>7 mos</b> |                                  |
| <b>Fracture intertrochanteric, right</b>  |   | <b>7 mos</b> |                                  |

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>?</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b> |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>1627 Thames St. 2-03</b> |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>Dec 23 1953 m.</b>  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><b>Slipped &amp; fell to floor</b>  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>Oct. 20 1952</b> , to <b>July 23 1953</b> , that I last saw the deceased alive on <b>July 23 1953</b> and that death occurred at <b>6:30A</b> m., from the causes and on the date stated above. |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>J.A. Hunter</b><br>J.A. Hunter, Clinical Director  |  | 23B. ADDRESS<br><b>US PHS Hospital, Balto, Md.</b>  |  | 23C. DATE SIGNED<br><b>7/27/53</b>  |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>JULY 28 1953</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>4430 BELAIR RD. MD</b>          |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 28 1953</b>  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  | 25. FUNERAL DIRECTOR<br><b>Deffel Bro.</b>  |  | ADDRESS<br><b>1800 E Lombard St.</b>  |  |
| VS 150  |  | <b>N-820.1</b>  |  | <b>75455</b>  |  |   |  |

CERTIFICATION APPROVED BY

Joseph G. J. Hunter, M.D.

M.D.

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THE UNIVERSITY OF CHICAGO

DEPARTMENT OF THE HISTORY OF ARTS

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6857**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**ELLA M. KELLY**2. DATE  
OF  
DEATH**July 27, 1953**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)**Md.****BALTO.**B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION**2136 Cliftwood Ave.**C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)**Essex**

D. STREET ADDRESS (If rural, give location)

**705 Mace Ave.**

c. Length of stay in Baltimore

5. SEX

**female**

6. COLOR OR RACE

**white**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**widowed**

8. DATE OF BIRTH

**Aug. 25, 1880**

9. AGE (In years last birthday) If Under 1 Year If Under 24 Hours

**72**10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**housewife**10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Maryland**12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Thomas M. Worthington**

14. MOTHER'S MAIDEN NAME

**Sophia Wolstrum**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
**Mrs. Bessie Amos - 2136 Cliftwood Ave.**

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

CAUSE OF DEATH

**Chronic Myocarditis**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

**Arteriosclerotic Cardio-vascular Disease**

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to **July 27, 1953**, that I last saw the  
deceased alive on **July 1, 1953**, and that death occurred at **11:15 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Burial****7/30/53****Loudon Park Cem.****Baltimore, Md.**DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**July 28, 1953****Huntington Williams, Jr.****Chm. J. Vickner & Sons****Balto. 17, Md.**

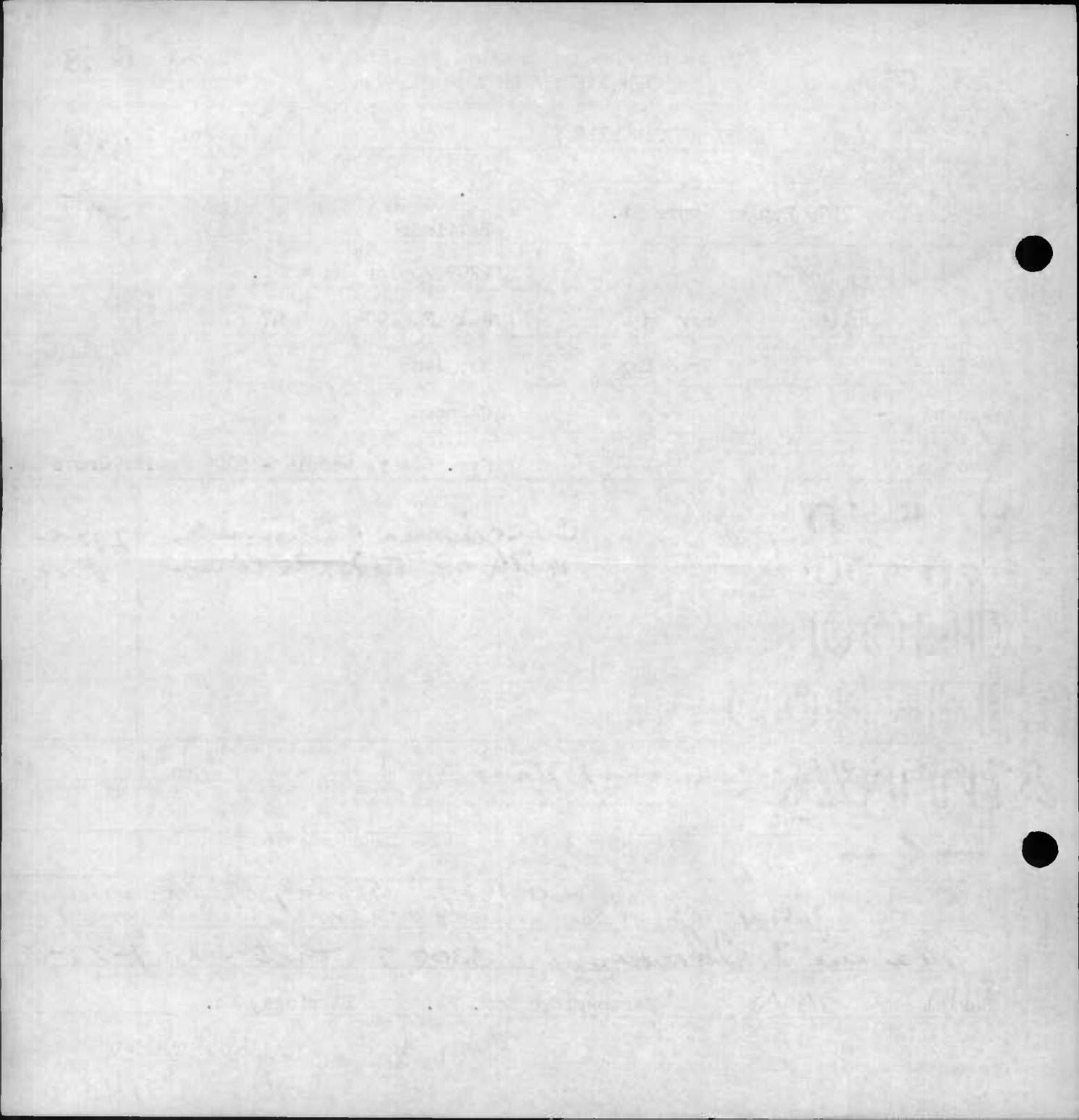
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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6858

W-340  
53 6858  
BIRTH NO.

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HENRY AUSTIN WEDDLE</b>  |                                  |  | 2. DATE OF DEATH<br><b>July 27, 1953</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE<br><b>Md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>2209 Poplar Grove St.</b>   |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                             |  |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>2209 Poplar Grove St.</b>  |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>                                      | 8. DATE OF BIRTH<br><b>July 2, 1906</b>  | 9. AGE (In years last birthday)<br><b>47</b>   | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>  |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>   |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |
| 13. FATHER'S NAME<br><b>Vernon</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  |  | 16. SOCIAL SECURITY NO.  |  |   |
| 17. INFORMANT<br><b>Mrs. Gladys Weddle</b>  |                                  |  | ADDRESS<br><b>- 2209 Poplar Grove St.</b>  |  |   |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>151X I</b><br><b>Carcinoma of Stomach</b><br>DUE TO <b>with extension to liver</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs plus.</b>   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                  |  | DUE TO (B) (C)   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |  |  |   |
| 19A. DATE OF OPERATION<br><b>January 7, 1953</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Stomach</b>                        |  | 19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II<br><b>No</b> |   |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 20C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                 |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>Oct. 27, 1953</b> to <b>July 27, 1953</b> , that I last saw the deceased alive on <b>July 24, 1953</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above.                              |                                  |  |  |  |   |
| 23A. SIGNATURE<br><b>Maurice Z. Shuman</b>  |                                  | 23B. ADDRESS<br><b>3300 W. North Ave.</b>  |  | 23C. DATE SIGNED<br><b>7-28-53</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7/30/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>                        |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Elkridge, Md.</b>   |                                  | 25. FUNERAL DIRECTOR<br><b>Thos. J. Tishener &amp; Sons</b>  |  |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Aug 28 1953</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |  |  |   |
| VS 150  |                                  | <b>55452</b><br><b>Balto. 17, Md.</b>  |  |  |   |





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6859**

BIRTH NO. **53 6859**

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Anna V. H. Stude</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 27, 1953</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>3018 N. Calvert St.</b>                                    |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>120</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, 12-02</b>                         |  |  |
| C. Length of stay in Baltimore <b>life</b><br>Yrs. _____<br>Mos. _____<br>Days _____                            |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>3018 N. Calvert St.</b>   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widow</b> | 8. DATE OF BIRTH<br><b>Dec. 2, 1877</b>   |  | 9. AGE (in years last birthday)<br><b>75</b><br>If Under 1 Year: Months: _____ Days: _____<br>If Under 24 Hours: Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |
| 13. FATHER'S NAME<br><b>Capt. Diedrick Holljes</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna S. Bultmann</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                  |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Mr. A. E. Stude Chadford Apts.</b>   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. <b>170x I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic carcinoma of liver and pelvis</b><br>(A) _____<br>DUE TO _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1951</b>                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Carcinoma of breast, right</b><br>(B) _____<br>DUE TO _____<br>(C) _____  |  |  |  | <b>1949</b>  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Hypertensive C-V disease</b>  |  |  |  | <b>1945</b>  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>m. _____ WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>Feb</b> , 19 <b>51</b> , to <b>July</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 26, 1953</b> , and that death occurred at <b>6:32A</b> m., from the causes and on the date stated above.                            |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Harry G. Kleinfelder</b>  |  | 23B. ADDRESS<br><b>1101 N. CALVERT St.</b>   |  | 23C. DATE SIGNED<br><b>7/28/53</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>July 29, 1953</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Fred. Ave. Baltimore, Md.</b>  |  |  |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 28 1953</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>John O. Mitchell 1900 Eutaw Place</b> |  |

8249

STATE OF TEXAS  
COUNTY OF DALLAS

1900

Blank document with faint horizontal lines and two punch holes on the right side.

2-563

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6860

BIRTH NO. 53 6860

|   |                           |  |  |  |   |
|---|---------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY T. CONRAD</b>                                |                           |  | 2. DATE OF DEATH <b>7-27-53</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2023 E. Hoffman St.</b>                          |                           |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 8-07</b>                     |  |   |
| C. Length of stay in Baltimore <b>72</b> Yrs. Mos. Days                                     |                           |  | D. STREET ADDRESS (If rural, give location) <b>2023 E. HOFFMAN St.</b>   |  |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b> | 8. DATE OF BIRTH <b>Nov. 16, 1865</b>  |  | 9. AGE (In years last birthday) <b>87</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>             | 11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>US</b>    |
| 13. FATHER'S NAME <b>FRANK Vancura</b>  |                           |  | 14. MOTHER'S MAIDEN NAME <b>Theresa</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>                 |                           | 16. SOCIAL SECURITY NO. <b>None</b>                            | 17. INFORMANT ADDRESS <b>William Conrad 2023 E. Hoffman St.</b>  |  |   |

|   |  |   |                                  |
|---|--|---|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) <b>Coronary Arteriosclerosis</b>  |  | <b>Chr. Myocarditis</b><br><b>Generalized Arterio Sclerosis</b> | <b>July 1, 53</b>                |
| (B) <b>Antecedent Causes</b>  |  |   | <b>Jan. 1, 45</b>                |
| (C) <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b>  |  |   | <b>Jan. 45</b>                   |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |                                  |

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1, 1945</b> to <b>July 27, 1953</b> , that I last saw the deceased alive on <b>July 27, 1953</b> and that death occurred at <b>1:30 P.m.</b> , from the causes and on the date stated above. |  |  |   |   |  |
| 23A. SIGNATURE <b>William J. Conrad</b> M. D.  |  | 23B. ADDRESS <b>801 E. Keenwood Rd</b>                                   |   | 23C. DATE SIGNED <b>7/28/53</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 24B. DATE <b>7-30-53</b>   | 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>                  | 24D. LOCATION (City, town, or county) (State) <b>Balta. Md.</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>8/1/53</b>   | REGISTRAR'S SIGNATURE <b>Huntington Williams</b>   | 25. FUNERAL DIRECTOR <b>Jerome C. Cusack</b>                             |   | ADDRESS <b>200 N. Chester St</b>                                      |  |

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 6861

BIRTH NO. 6861

1. NAME OF DECEASED  
(Type or Print)

TUCKER Katherine

2. DATE  
OF  
DEATH

7/26/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Russell Tucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

133 McPhail St

8. DATE OF BIRTH

7/3/41

9. AGE (In years last birthday)

12

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore?

12. CITIZEN OF WHAT COUNTRY?

US

14. MOTHER'S MAIDEN NAME

Nelson Lucile

17. INFORMANT

Mr Russell Tucker

ADDRESS

133 McPhail

18.

754.6  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Congestive Heart failure  
Aortic Stenosis (Congenital)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Bacterial Pneumonia

(C)

Secondary to above

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DIED (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DIED INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/3/1953, 19, to 7/26/1953, 19, that I last saw the deceased alive on 7/23/1953, 19, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

J. Pearson

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

7/26/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7-29-53

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's City

24D. LOCATION (City, town, or county)

Greenmount &amp; 20th St

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

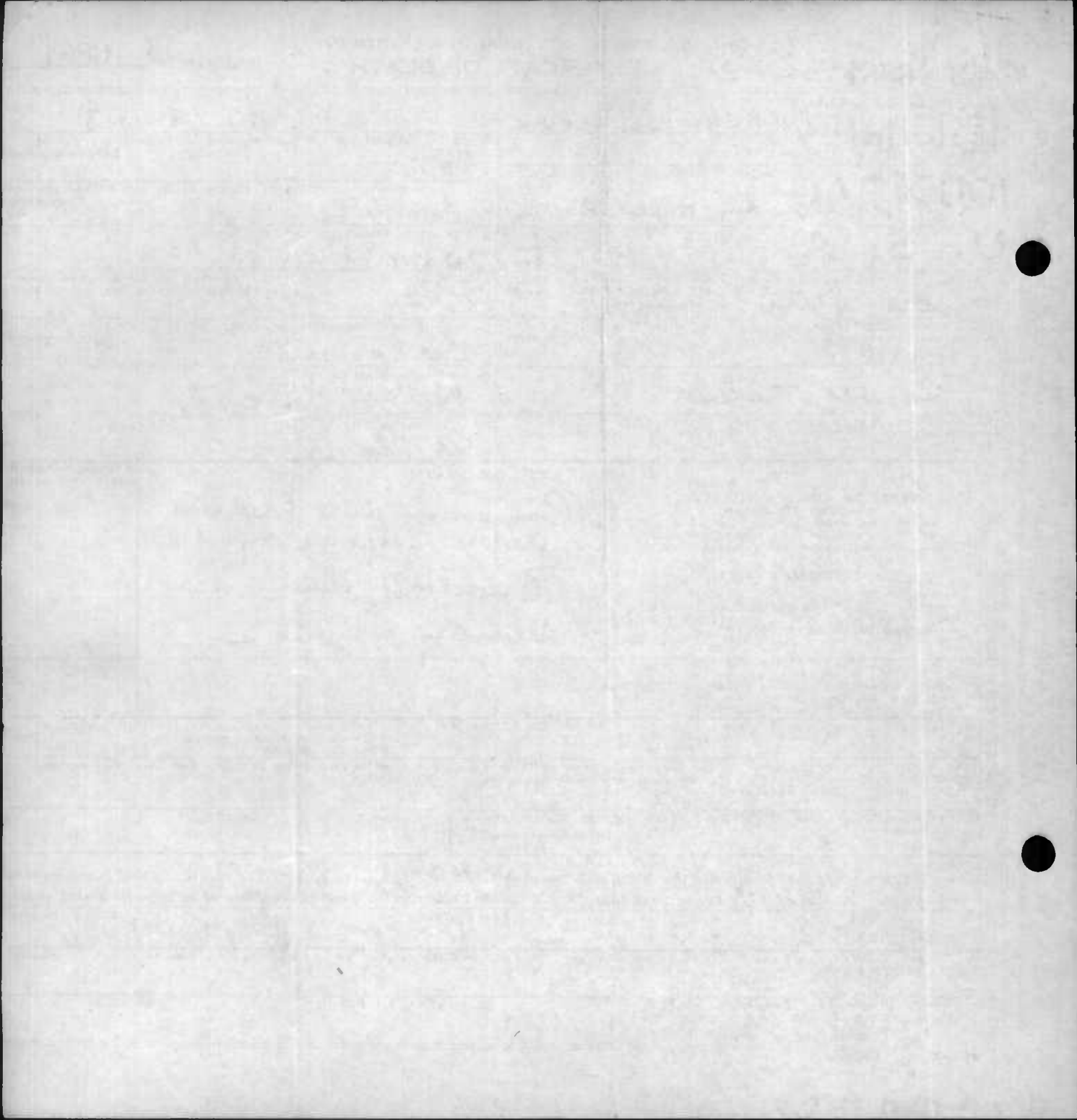
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Huntington Williams, M.D.

ADDRESS

Huntington Williams, M.D.







Admission

Section

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100-4-84

100-4-84

100-4-84

240

3 6863

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6863  
Registered No.

|  |   |   |   |
|--|---|---|---|
| NAME OF DECEASED<br>(Last, first, middle, or Print) <b>ELSIE A. RUSSELL</b>  |   | 2. DATE OF DEATH <b>July 27 '53</b>   |   |
| PLACE OF DEATH: <b>Baltimore, Md</b>   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |   |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Lutheran Hospital of Maryland</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore (DUNDALK 22)</b>                                   |   |
| Length of stay in Baltimore <b>10</b>  |   | D. STREET ADDRESS (If rural, give location)<br><b>7 Arrowship Road Balto. 22. Md.</b>   |   |
| 5. SEX <b>F.</b>   | 6. COLOR OR RACE <b>W.</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>   | 8. DATE OF BIRTH <b>12/6/1881</b>   |
| 9. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10. JOB, KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>71</b>   |
| FATHER'S NAME<br><b>CHAS A. GOULD</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT <b>Sum-in-low</b><br><b>Herbert H. Grauerkes.</b>                     |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNA (?)</b>  |   | ADDRESS<br><b>Same</b>  |   |
| B. <b>331X</b>   |   | CAUSE OF DEATH  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |   | (A) <b>Cerebral Vascular Accident.</b>  |   |
| ANTECEDENT CAUSES  |   | DUE TO  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | (B) <del>Hypertension</del>   |   |
| II   |   | (C) <b>Hypertension</b>   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.   |   | <b>Hypertension and Cardio Vascular disease</b>   |   |
| 19A. DATE OF OPERATION   | 19B. MAJOR FINDINGS OR OPERATION  |   | 20. AUTOPSY?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>July 20</b> , 19 <b>53</b> , to <b>July 27</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 27</b> , 19 <b>53</b> , and that death occurred at <b>8:26</b> <b>PM</b> , from the causes and on the date stated above. |   |   |   |
| 23A. SIGNATURE<br><b>NORA Chang</b>  | 23B. ADDRESS<br><b>Lutheran Hosp.</b>   | 23C. DATE SIGNED<br><b>July 27, 53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>URIAL</b>  | 24B. DATE<br><b>7-31-53</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>HEPHZIBAH</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>MOORENA, PENNA.</b>             |
| 25. FUNERAL DIRECTOR<br><b>Huntington Williams</b>   | 25. FUNERAL DIRECTOR<br><b>Walter Burke Bradley, Dundalk, Md.</b>   |   |   |

VS 150

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

400  
3 6864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6864  
Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

*Herbert Curtis Bailey*

2. DATE  
OF  
DEATH

*7-28-53*

PLACE OF DEATH:  
Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*728 Dolphin St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Balto.*

*17-03*

D. STREET ADDRESS (If rural, give location)

*728 Dolphin St*

Length of stay in Baltimore

EX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*8-25-88*

9. AGE (In years  
last birthday)

*64*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)

*Store clerk*

10B. KIND OF BUSINESS OR  
INDUSTRY

*-*

11. BIRTHPLACE (State or foreign country)

*Va*

12. CITIZEN OF  
WHAT COUNTRY?

*U. S.*

FATHER'S NAME

14. MOTHER'S MAIDEN NAME

*?*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown

16. SOCIAL  
SECURITY NO.

*215-07-5563*

17. INFORMANT

ADDRESS

*725 Bopke*

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Cerebral Hemorrhage*

DUE TO

ANTECEDENT CAUSES

(B)

*Hypertensive C. V. Disease*

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 1943*, to *July 28, 1953*, that I last saw the  
deceased alive on *7-24, 1953*, and that death occurred at *10:45 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Dr. Campbell*

23B. ADDRESS

*1709 Guinness Falls Pkwy*

23C. DATE SIGNED

*7-28-53*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

*7-31-53*

24C. NAME OF CEMETERY OR CREMATORY

*Calverton Mem. Park*

24D. LOCATION (City, town, or county)

*Balto. Md.*

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*Samuel W. Sullivan*

VS 150

*94055 1011 N. Anlington Ave*

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

31



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **53 6865**

|  |                                 |   |                                |
|--|---------------------------------|---|--------------------------------|
| 1. NAME OF DECEASED (or Print) <b>EMMA PRATT</b>   |                                 | 2. DATE OF DEATH <b>July 26, 1953</b>   |                                |
| 3. PLACE OF DEATH: <b>Baltimore City, Maryland</b>   |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |                                |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>27 N. Carey St.</b>  |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |                                |
| 6. LENGTH OF stay in Baltimore<br><b>18-02</b>   |                                 | D. STREET ADDRESS (If rural, give location)<br><b>27 N. Carey St.</b>   |                                |
| 7. SEX <b>Female</b>   | 8. COLOR OR RACE <b>Colored</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>  | 10. B. DATE OF BIRTH <b>78</b> |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Housewife</b>  |                                 | 12. AGE (In years last birthday) <b>78</b>  |                                |
| 13. FATHER'S NAME <b>William Coates</b>  |                                 | 14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                 | 16. SOCIAL SECURITY NO.   |                                |
| 17. INFORMANT <b>Mrs. Grace Casper</b>   |                                 | ADDRESS <b>2044 Braddish Ave.</b>   |                                |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Interventricular Conduction System Block</b><br>DUE TO<br><b>Myocardial Infarction</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>None</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                 | 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |                                |
| 20. DATE OF OPERATION <b>0</b>   |                                 | 21. MAJOR FINDINGS OF OPERATION   |                                |
| 22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                 | 23. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                |
| 24. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                 | 25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                |
| 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                 | 27. HOW DID INJURY OCCUR?   |                                |
| 28. I hereby certify that I attended the deceased from <b>10-10-1952</b> to <b>7-26-1953</b> ; that I last saw the deceased alive on <b>7-26-1953</b> , and that death occurred at <b>7:00 p.m.</b> , from the causes and on the date stated above.  |                                 |   |                                |
| 29. SIGNATURE <b>Charles T. Woolley</b>  |                                 | 30. ADDRESS <b>861 Vardon St.</b>   |                                |
| 31. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                 | 32. DATE <b>7-30-53</b>   |                                |
| 33. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>   |                                 | 34. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>  |                                |
| 35. RECEIVED BY REGISTAR <b>Huntington Hallahan, Jr.</b>   |                                 | 36. FUNERAL DIRECTOR <b>Mrs. Frances A. Kinsley</b>   |                                |
| 37. VS 150   |                                 | 38. ADDRESS <b>578 W. 1st St.</b>   |                                |

*[Faint, illegible handwriting throughout the page]*

525

53 6866

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

53 6866

TH NO.

NAME OF DECEASED  
(in full or Print)

James Johnson

2. DATE  
OF  
DEATH

7-27-53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
(If not in hospital or institution, give street address or  
location)

Provident Hosp.

HOSPITAL OR  
INSTITUTION

Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

Balt.

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

398 W. Biddle St

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

unk

8. DATE OF BIRTH

9-25-83

9. AGE (In years  
last birthday)

69

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Payton Johnson

14. MOTHER'S MAIDEN NAME

Fannie?

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown

16. SOCIAL  
SECURITY NO.

unk

17. INFORMANT

ADDRESS

Hospital Records

8. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Intestinal Obstruction

3 days

ANTECEDENT CAUSES

(B)

DUE TO

Chr. Pulm. Dis. R.O. Tbc.

?

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Malnutrition + Dehydration

?

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

none

none

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

OF INJURY

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7/26, 1953, to 7/27, 1953, that I last saw the  
deceased alive on 7/27/53, 1953, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

William L. Farmer Jr.

M. D. Provident Hosp.

7/28/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

26. RECEIVED BY  
LOCAL REGISTRAR

Huntington Williams, M.D.

Halstead - 9/8 -

27. RECEIVED BY  
LOCAL REGISTRAR

Huntington Williams, M.D.

Halstead - 9/8 -

28. RECEIVED BY  
LOCAL REGISTRAR

Huntington Williams, M.D.

Halstead - 9/8 -

29. RECEIVED BY  
LOCAL REGISTRAR

Huntington Williams, M.D.

Halstead - 9/8 -

VS 150

Bluid Hill Ave.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6867  
Registered No.

BIRTH NO.

|  |                                    |   |  |   |  |
|--|------------------------------------|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANDREW C. MURRAY</b>   |                                    |   | 2. DATE OF DEATH<br><b>July 21, 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland Balto. City  |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Morgue</b>  |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>5-02</b>                   |   |  |
| C. Length of stay in Baltimore <b>50 Yrs.</b><br>Yrs. Mos. Days  |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>411 Freeland St.</b>   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH   |   | 9. AGE (In years last birthday)<br><b>57</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Handy Man</b>  |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Poultry</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Easternshore Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b> |
| 13. FATHER'S NAME<br><b>John E. Murray</b>   |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes War # 1</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>220-03-5196</b>   |  | 17. INFORMANT ADDRESS<br><b>Agnes Murray 1018 N. Dallas St</b>                      |  |
| 18. <b>4720.1</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) <b>Coronary artery sclerosis</b><br>DUE TO<br>ANTECEDENT CAUSES<br>(B) <b>Bronchopneumonia</b><br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                    |   |  |   | INTERVAL BETWEEN ONSET AND DEATH             |
| 19A. DATE OF OPERATION   |                                    | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                    | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                     |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .  |                                    |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b>  |                                    | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR |  | 23C. DATE SIGNED<br><b>July 21, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7/29/1953</b>      | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat. Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>               |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                                    | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  | FUNERAL DIRECTOR ADDRESS<br><b>Elroy O Williams</b>                                 |  |





230

3 6868

## BALTIMORE CITY HEALTH DEPARTMENT

53 6868

TH NO.

53-16598

## CERTIFICATE OF DEATH

Registered No.

NAME OF DECEASED  
(Last, first, middle, or Print)

Edward Thomas Faust, Jr.

2. DATE  
OF  
DEATH

July 26, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

Provident Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

510 New Pittsburg Ave.

Length of stay in Baltimore

11

Yrs.  
Mos.  
Days

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July 16, 1953

9. AGE (in years  
last birthday)If Under 1 Year  
Months: Days Hours Min.

11

USUAL OCCUPATION (Give kind of  
work during most of working life, or if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Edward Thomas Faust

14. MOTHER'S MAIDEN NAME

Sandra Augusta Tighman

HAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS  
Mother

B.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

Hemorrhagic disease  
of the newborn

(A) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
6-14 1/2

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)1d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

2. I hereby certify that I attended the deceased from 7-16, 1953, to 1-26, 1953, that I last saw the deceased alive on 7-26, 1953, and that death occurred at 10:55 a.m., from the causes and on the date stated above.

3A. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

BURIAL, CREMA-  
TION, OR REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

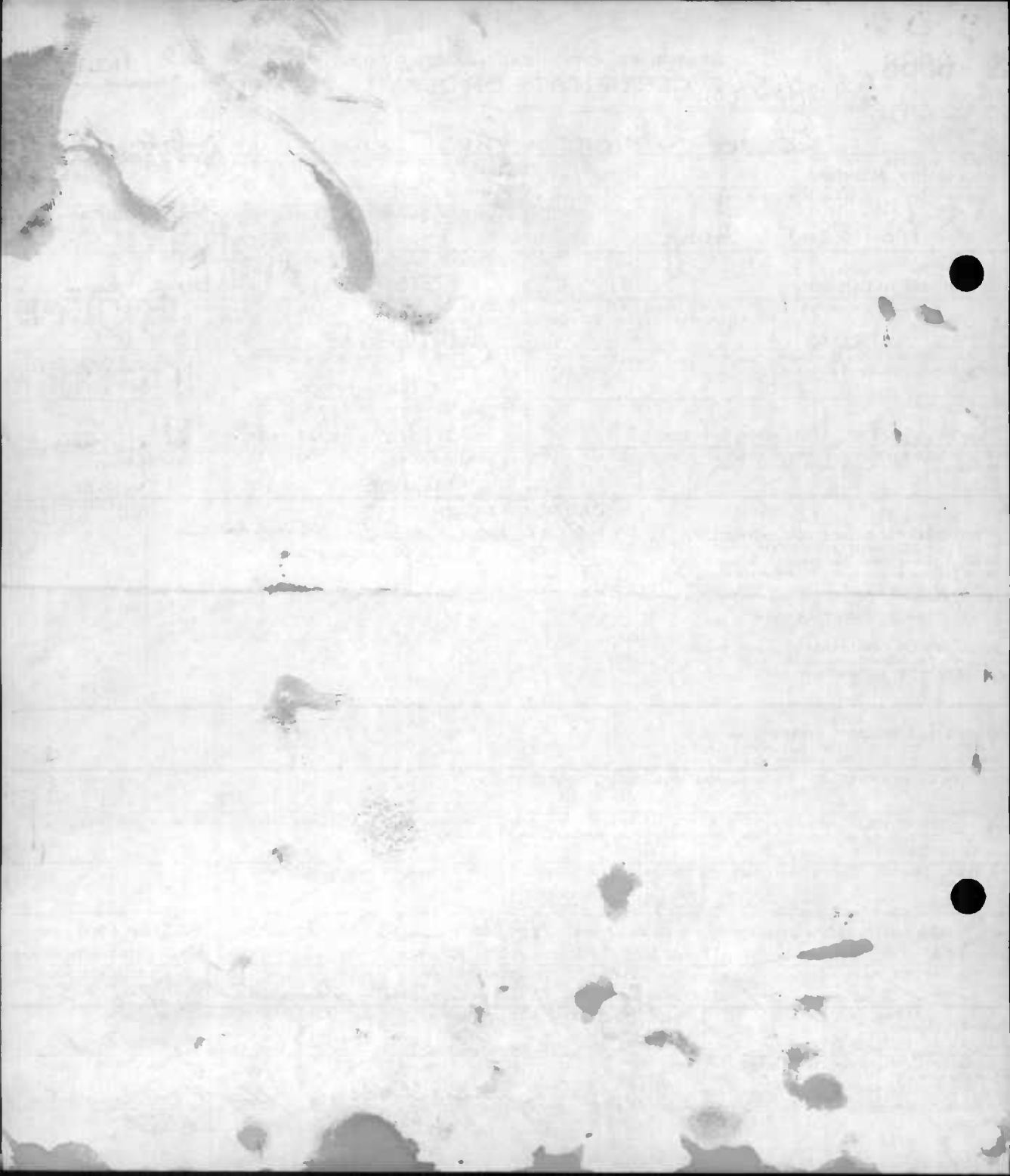
RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150



MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6869

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Mary Gladys Traynham*

2. DATE  
OF  
DEATH

*July 28, 1953*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*08 4*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*md.*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*1017 N. Caroline St.*

C. Length of stay in Baltimore

*24 yrs*

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

*Female*

*Colored*

*Married*

8. DATE OF BIRTH

*7/23/1900*

9. AGE (In years

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Alton Virginia*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Thomas Warren*

14. MOTHER'S MAIDEN NAME

*Katie Warren*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JOHNS HOPKINS HOSPITAL*

18.

*331X I*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*arterial msc. accident.*

*12 hr.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/28*, 19*53*, to *7/28*, 19*53*, that I last saw the deceased alive on *7/28*, 19*53* and that death occurred at *1:45* p. m., from the causes and on the date stated above.

23A. SIGNATURE

*W. E. Morrison Jr.*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial July 31/53*

*Palmer National Cem.*

*Frederick Rd. Md.*

*Huntington Williams*

*Mr. R. H. G. Elliott, Daughter*

VS 150

*1129 N. Caroline St*

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

On the ... day of ...

at ...

... died ...

... at the age of ...

... cause of death ...

... signed by ...

... at ...

...

...

...

...

...

...

...

...

...

...

...

N-550

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6870  
Registered No.53 6870  
BIRTH NO.

|   |                                  |   |  |   |                                  |
|---|----------------------------------|---|--|---|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Henry J. Naumann</b>  |                                  |   | 2. DATE OF DEATH<br><b>26 JULY 53</b>  |   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>22436 W Charles</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>100</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write FULL and give township)<br><b>Balto</b> <b>10-02</b>                 |   |                                  |
| c. Length of stay in Baltimore <b>Life</b>  |                                  |   | O. STREET ADDRESS (If rural, give location)<br><b>Abbeville Court</b>  |   |                                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>  | 8. DATE OF BIRTH<br><b>April 25 1886</b>   | 9. AGE (In years last birthday)<br><b>67</b>                                | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Iron Moulder ret'd</b>  |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |   |                                  |
| 13. FATHER'S NAME<br><b>Henry Naumann</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Helfenbein</b>  |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  |   | 16. SOCIAL SECURITY NO.  |   |                                  |
| 17. INFORMANT<br><b>Elizabeth Herschel</b>  |                                  |   | ADDRESS<br><b>2116 W Charles St</b>  |   |                                  |
| 18. <b>490X</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia, Lobar, LLL</b><br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |                                  |   |  |   |                                  |
| 18. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(C)   |                                  |   |  |   |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Generalized Arteriosclerosis</b>   |                                  |   |  |   | <b>Indef.</b>                    |
| 19A. DATE OF OPERATION  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II |                                  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |   |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |                                  |
| 22. I hereby certify that I attended the deceased from <b>21 July</b> , 19 <b>53</b> to <b>26 July</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>25 July</b> , 19 <b>53</b> and that death occurred at <b>11 A</b> m., from the causes and on the date stated above.  |                                  |   |  |   |                                  |
| 23A. SIGNATURE<br><b>Blair B. Williams</b>  |                                  | 23B. ADDRESS<br><b>2020 N. Charles St</b>   |  | 23C. DATE SIGNED<br><b>28 July 53</b>                                       |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>July 29 53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Matthew C.</b>                 |                                  |
| 24D. LOCATION (City, town, or county)<br><b>Balto</b>   |                                  | 24E. LOCATION (City, town, or county)<br><b>Balto</b>   |  |   |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 29 1953</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  | 25. FUNERAL DIRECTOR<br><b>William L. Home</b>                              |                                  |
| ADDRESS<br><b>2112 Dandalk Ave</b>  |                                  |   |  |   |                                  |

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



1-455

6871

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6871

Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

Mary (Mamie) Wellmann

2. DATE

OF DEATH July 27/53

PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1854 Wilkens Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 19-04

D. STREET ADDRESS (If rural, give location)

1854 Wilkens Ave

Length of stay in Baltimore Life

EX 6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

May 24, 1889

9. AGE (in years last birthday)

64

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

Harry Musgrove

14. MOTHER'S MAIDEN NAME

Anna Hettinger

HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Wm H. Wellmann, 1854 Wilkens Ave

3. 4/4/2 x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Thrombosis 3 days  
DUE TO(B) Cerebral Vascular Punct Lesion  
DUE TO  
(C) Generalized Arteriosclerosis 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

OF INJURY

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1, 1948 to July 27, 1953 that I last saw the deceased alive on July 26, 1953 and that death occurred at 10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

RECEIVED BY AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Huntington Williams Harry A. Smith 4101 Edmondson Ave.

AMERICAN BUREAU OF HEALTH  
CERTIFICATE OF DEATH

|                                 |  |                                 |  |                                       |  |                                  |  |
|---------------------------------|--|---------------------------------|--|---------------------------------------|--|----------------------------------|--|
| 1. Name of deceased             |  | 2. Sex                          |  | 3. Age                                |  | 4. Date of death                 |  |
| 5. Place of death               |  | 6. Cause of death               |  | 7. Manner of death                    |  | 8. Signature of physician        |  |
| 9. Signature of registrar       |  | 10. Signature of undertaker     |  | 11. Signature of funeral home         |  | 12. Signature of cemetery        |  |
| 13. Signature of health officer |  | 14. Signature of coroner        |  | 15. Signature of justice of the peace |  | 16. Signature of other official  |  |
| 17. Signature of other official |  | 18. Signature of other official |  | 19. Signature of other official       |  | 20. Signature of other official  |  |
| 21. Signature of other official |  | 22. Signature of other official |  | 23. Signature of other official       |  | 24. Signature of other official  |  |
| 25. Signature of other official |  | 26. Signature of other official |  | 27. Signature of other official       |  | 28. Signature of other official  |  |
| 29. Signature of other official |  | 30. Signature of other official |  | 31. Signature of other official       |  | 32. Signature of other official  |  |
| 33. Signature of other official |  | 34. Signature of other official |  | 35. Signature of other official       |  | 36. Signature of other official  |  |
| 37. Signature of other official |  | 38. Signature of other official |  | 39. Signature of other official       |  | 40. Signature of other official  |  |
| 41. Signature of other official |  | 42. Signature of other official |  | 43. Signature of other official       |  | 44. Signature of other official  |  |
| 45. Signature of other official |  | 46. Signature of other official |  | 47. Signature of other official       |  | 48. Signature of other official  |  |
| 49. Signature of other official |  | 50. Signature of other official |  | 51. Signature of other official       |  | 52. Signature of other official  |  |
| 53. Signature of other official |  | 54. Signature of other official |  | 55. Signature of other official       |  | 56. Signature of other official  |  |
| 57. Signature of other official |  | 58. Signature of other official |  | 59. Signature of other official       |  | 60. Signature of other official  |  |
| 61. Signature of other official |  | 62. Signature of other official |  | 63. Signature of other official       |  | 64. Signature of other official  |  |
| 65. Signature of other official |  | 66. Signature of other official |  | 67. Signature of other official       |  | 68. Signature of other official  |  |
| 69. Signature of other official |  | 70. Signature of other official |  | 71. Signature of other official       |  | 72. Signature of other official  |  |
| 73. Signature of other official |  | 74. Signature of other official |  | 75. Signature of other official       |  | 76. Signature of other official  |  |
| 77. Signature of other official |  | 78. Signature of other official |  | 79. Signature of other official       |  | 80. Signature of other official  |  |
| 81. Signature of other official |  | 82. Signature of other official |  | 83. Signature of other official       |  | 84. Signature of other official  |  |
| 85. Signature of other official |  | 86. Signature of other official |  | 87. Signature of other official       |  | 88. Signature of other official  |  |
| 89. Signature of other official |  | 90. Signature of other official |  | 91. Signature of other official       |  | 92. Signature of other official  |  |
| 93. Signature of other official |  | 94. Signature of other official |  | 95. Signature of other official       |  | 96. Signature of other official  |  |
| 97. Signature of other official |  | 98. Signature of other official |  | 99. Signature of other official       |  | 100. Signature of other official |  |

A-614

3 6872

TH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6872

NAME OF DECEASED  
(Type or Print)

LAWRENCE J. MARFIELD

2. DATE  
OF  
DEATH

JULY 25, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

LUTHERAN HOSPITAL OF MARYLAND

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY 19-04

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE, MARYLAND

D. STREET ADDRESS (If rural, give location)

1810 WILKINS AVE

SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 25, 1894

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10. USUAL OCCUPATION (Give kind of  
work during most of working life, even if retired)

POLICEMAN, retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Balto. City Police

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

George Marfield

14. MOTHER'S MAIDEN NAME

Jennie

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs L. Marfield, 1810 Wilkens Ave

18. 443X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) DUE TO

ACUTE GENERALIZED CONGESTIVE  
AND CHRONIC HEART FAILURE

(B) DUE TO

HYPERTENSIVE ARTERIOSCLEROTIC  
CARDIOVASCULAR DISEASE  
AND CIRRHOSIS OF LIVER

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATHMORE THAN  
5 YEARS  
MORE THAN  
5 YEARS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1953 to July 25, 1953, that I last saw the  
deceased alive on July 25, 1953, and that death occurred at 3:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William D. Rossen M.D.

23B. ADDRESS

Lutheran Hospital of Md.

23C. DATE SIGNED

7/25/53

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24A. DATE

Aug. 1/53

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Balto. Md.

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

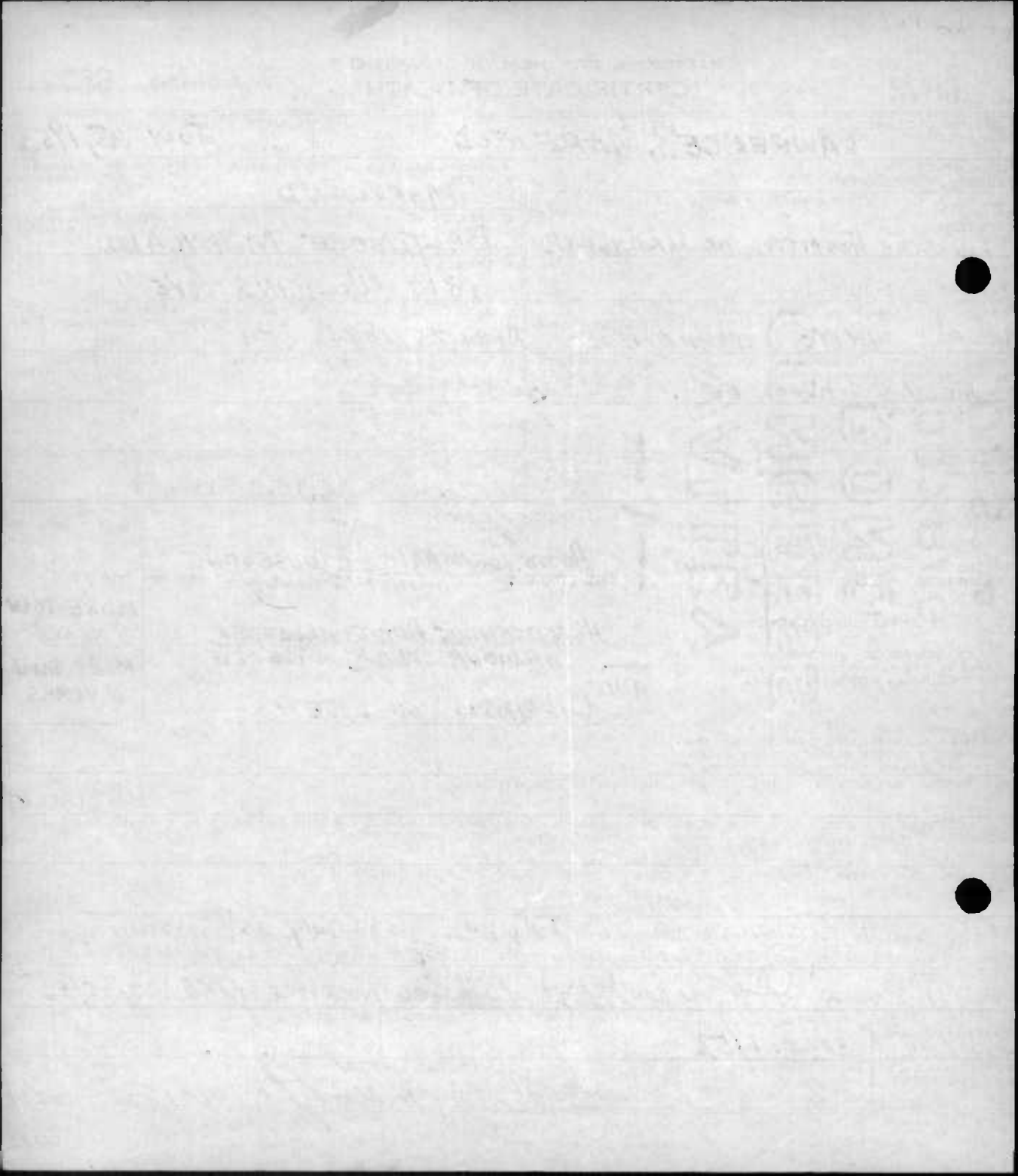
ADDRESS

Harry F. Kutzke, 4101 Edmondson

VS 150

773 93

Am



- 200

53 6873

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6873

Registered No. \_\_\_\_\_

TH NO.

NAME OF DECEASED  
(Last name or Print)

Anna M. Loesch

2. DATE  
OF  
DEATH

July 28, 1953

PLACE OF DEATH:

Baltimore City, Maryland

Baltimore, Md.

FULL NAME OF

(If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

612 Wildwood Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

(If outside corporate limits, write RURAL and township)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and township)

D. STREET ADDRESS (If rural, give location)

612 Wildwood Parkway

-16-08-

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 24, 1861

9. AGE (In years  
last birthday)

92

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10. USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

I.V.

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Christian Goepfert

14. MOTHER'S MAIDEN NAME

Ottilie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles J. Loesch, 612 Wildwood Pkwy.

8.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocarditis (Cardio-sclerotic) 5 yrs.

ANTECEDENT CAUSES

DUE TO

(B)

Arterio-sclerosis 20 "

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Advanced Age

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from June 4, 1953 to July 28, 1953 that I last saw the  
deceased alive on July 27, 1953, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 30/53

Western Cemetery

Baltimore Md.

25A. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25B. FUNERAL DIRECTOR

ADDRESS

25C. DATE SIGNED

25D. ADDRESS

25E. DATE SIGNED

25F. ADDRESS

25G. DATE SIGNED

25H. ADDRESS

25I. DATE SIGNED

25J. ADDRESS

25K. DATE SIGNED

25L. ADDRESS

25M. DATE SIGNED

25N. ADDRESS

25O. DATE SIGNED

25P. ADDRESS

25Q. DATE SIGNED

25R. ADDRESS

25S. DATE SIGNED

25T. ADDRESS

25U. DATE SIGNED

25V. ADDRESS

25W. DATE SIGNED

25X. ADDRESS

25Y. DATE SIGNED

25Z. ADDRESS

25AA. DATE SIGNED

25AB. ADDRESS

25AC. DATE SIGNED

25AD. ADDRESS

25AE. DATE SIGNED

25AF. ADDRESS

25AG. DATE SIGNED

25AH. ADDRESS

25AI. DATE SIGNED

25AJ. ADDRESS

25AK. DATE SIGNED

25AL. ADDRESS

25AM. DATE SIGNED

25AN. ADDRESS

25AO. DATE SIGNED

25AP. ADDRESS

25AQ. DATE SIGNED

25AR. ADDRESS

25AS. DATE SIGNED

25AT. ADDRESS

25AU. DATE SIGNED

25AV. ADDRESS

25AW. DATE SIGNED

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25AY. DATE SIGNED

25AZ. ADDRESS

25BA. DATE SIGNED

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25BC. DATE SIGNED

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25BJ. ADDRESS

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25BS. DATE SIGNED

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25BU. DATE SIGNED

25BV. ADDRESS

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25BV. ADDRESS

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25CH. ADDRESS

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200-500

100-100

100-100

ACTIVE

100-100



452

6874

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6874  
Registered No.

NAME OF DECEASED  
(Last, first, middle, or Print)

Rachel Mina Willyoung

2. DATE  
OF  
DEATH

July 28/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
Hillcrest Nursing Home  
212 Stoney Run Lane

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY BALTO

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore CA/ONSVILLE

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

EX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July 28, 1883

9. AGE (in years last birthday)

70

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

John Hubner

14. MOTHER'S MAIDEN NAME

Mary

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Martin Enders, Fredericksburg Va.

8. 470.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

1. Arteriosclerotic Heart Disease

2. Hypertensive C.V.D.

3. 1. Hemiparesis from artery Brain

arteriosclerosis & hemiparesis

4. Hypostatic pneumonia

INTERVAL BETWEEN ONSET AND DEATH

5-10 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1953, to July 28, 1953, that I last saw the deceased alive on July 27, 1953, and that death occurred at 4:00 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 29/53

Loudon Park Cemetery Balto. Md.

25. RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

25. RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

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REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

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25. RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

18-22

CERTIFICATE OF DEATH

AND STATE OF NEW YORK

|                               |  |                            |  |                               |  |                                   |  |
|-------------------------------|--|----------------------------|--|-------------------------------|--|-----------------------------------|--|
| 1. Name of deceased           |  | 2. Sex                     |  | 3. Age                        |  | 4. Date of death                  |  |
| 5. Place of death             |  | 6. Cause of death          |  | 7. Manner of death            |  | 8. Signature of physician         |  |
| 9. Signature of registrar     |  | 10. Signature of informant |  | 11. Signature of witness      |  | 12. Signature of funeral director |  |
| 13. Signature of undertaker   |  | 14. Signature of cemetery  |  | 15. Signature of burial place |  | 16. Signature of interment        |  |
| 17. Signature of burial place |  | 18. Signature of interment |  | 19. Signature of burial place |  | 20. Signature of interment        |  |
| 21. Signature of burial place |  | 22. Signature of interment |  | 23. Signature of burial place |  | 24. Signature of interment        |  |
| 25. Signature of burial place |  | 26. Signature of interment |  | 27. Signature of burial place |  | 28. Signature of interment        |  |
| 29. Signature of burial place |  | 30. Signature of interment |  | 31. Signature of burial place |  | 32. Signature of interment        |  |
| 33. Signature of burial place |  | 34. Signature of interment |  | 35. Signature of burial place |  | 36. Signature of interment        |  |
| 37. Signature of burial place |  | 38. Signature of interment |  | 39. Signature of burial place |  | 40. Signature of interment        |  |
| 41. Signature of burial place |  | 42. Signature of interment |  | 43. Signature of burial place |  | 44. Signature of interment        |  |
| 45. Signature of burial place |  | 46. Signature of interment |  | 47. Signature of burial place |  | 48. Signature of interment        |  |
| 49. Signature of burial place |  | 50. Signature of interment |  | 51. Signature of burial place |  | 52. Signature of interment        |  |
| 53. Signature of burial place |  | 54. Signature of interment |  | 55. Signature of burial place |  | 56. Signature of interment        |  |
| 57. Signature of burial place |  | 58. Signature of interment |  | 59. Signature of burial place |  | 60. Signature of interment        |  |
| 61. Signature of burial place |  | 62. Signature of interment |  | 63. Signature of burial place |  | 64. Signature of interment        |  |
| 65. Signature of burial place |  | 66. Signature of interment |  | 67. Signature of burial place |  | 68. Signature of interment        |  |
| 69. Signature of burial place |  | 70. Signature of interment |  | 71. Signature of burial place |  | 72. Signature of interment        |  |
| 73. Signature of burial place |  | 74. Signature of interment |  | 75. Signature of burial place |  | 76. Signature of interment        |  |
| 77. Signature of burial place |  | 78. Signature of interment |  | 79. Signature of burial place |  | 80. Signature of interment        |  |
| 81. Signature of burial place |  | 82. Signature of interment |  | 83. Signature of burial place |  | 84. Signature of interment        |  |
| 85. Signature of burial place |  | 86. Signature of interment |  | 87. Signature of burial place |  | 88. Signature of interment        |  |
| 89. Signature of burial place |  | 90. Signature of interment |  | 91. Signature of burial place |  | 92. Signature of interment        |  |
| 93. Signature of burial place |  | 94. Signature of interment |  | 95. Signature of burial place |  | 96. Signature of interment        |  |
| 97. Signature of burial place |  | 98. Signature of interment |  | 99. Signature of burial place |  | 100. Signature of interment       |  |

635

3 6875

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6875

NAME OF DECEASED (Type or Print) **MARY E FORTHMAN**

2. DATE OF DEATH **July 28, 1953**

PLACE OF DEATH: **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)  
A. STATE **md.**  
B. COUNTY **13-05**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Balta**

D. STREET ADDRESS (If rural, give location)  
**806 W. 32nd St.**

Length of stay in Baltimore  
Yrs. **1**  
Mos. **1**  
Days **1**

SEX **Female**

6. COLOR OR RACE **White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widowed**

8. DATE OF BIRTH **April 25, 1866**

9. AGE (In years last birthday) **87**

10. BIRTHPLACE (State or foreign country) **md.**

11. CITIZEN OF WHAT COUNTRY? **md.**

A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)  
**-**

10B. KIND OF BUSINESS OR INDUSTRY **-**

FATHER'S NAME **-**

14. MOTHER'S MAIDEN NAME **-**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
**-**

16. SOCIAL SECURITY NO. **7**

17. INFORMANT ADDRESS  
**Mildred H. Hare 802 W. 32nd St.**

18. **422.1**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Acute Myocardial Failure**

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**Chronic Myocarditis**  
**Atherosclerosis**

19. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 1**, 1953, to **7-28**, 1953, that I last saw the deceased alive on **7-28**, 1953, and that death occurred at **m.**, from the causes and on the date stated above.

23A. SIGNATURE **Loungfless** M. O. **2730 N. Charles St.**

23C. DATE SIGNED **7/29/53**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE **July 31, 1953**

24C. NAME OF CEMETERY OR CREMATORY **Lorraine Park**

24D. LOCATION (City, town, or county) (State)  
**Windsor Mill Rd.**

25. FUNERAL DIRECTOR ADDRESS  
**Huntington Williams, Paul C. Chism, 3655 N. Chateaufort Ave**

JUL 29 1953

VS 150



1-246

3 6876

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6876

TH NO.

NAME OF DECEASED  
(Last, first, middle, or initial)

WILLIAM S McCLEARY

2. DATE  
OF  
DEATH

July 27-53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF  
HOSPITAL OR  
NURSING HOME  
(If not in hospital or institution, give street address or location)Ardleigh Nursing Home  
Broad & Parkdale Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS

(If rural, give location)

Yrs.  
Mos.  
Days

711 N 33rd St

Length of stay in Baltimore

50 yrs

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov 8-1877

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10. UPWARD OCCUPATION (Give kind of  
work during life, even if retired)

Picture frame maker

10B. KIND OF BUSINESS OR  
INDUSTRY

Picture frame mfg

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-01-8963

17. INFORMANT

ADDRESS

Wm E Hebb, 3807 Elm Ave

18. 443 X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Cerebral Hemorrhage

Arteriosclerosis CVD

Hypertension

INTERVAL BETWEEN  
ONSET AND DEATH

5 days

?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK22. I hereby certify that I attended the deceased from 7-27, 1953 to 7-27, 1953, that I last saw the  
deceased alive on 7-27, 1953, and that death occurred at 1055 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24. BURIAL, CREMA-  
TION (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25. RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

10

CERTIFICATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. OCCUPATION  
7. MARITAL STATUS  
8. EDUCATION  
9. RELIGION

10. CAUSE OF DEATH  
11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR

14. PLACE OF DEATH  
15. DATE OF DEATH

16. SIGNATURE OF DECEASED  
17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED  
19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED  
21. SIGNATURE OF WITNESSES

22. SIGNATURE OF DECEASED  
23. SIGNATURE OF WITNESSES



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6877

Registered No.

53 6877

BIRTH NO.

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Margaret C. Bisese</b>  |                                  |   | 2. DATE OF DEATH <b>July 27, 1953</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>1030 W. Barre Street</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>21-01</b>     |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1030 W. Barre Street</b>  |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Sept. 3, 1903</b>  |  | 9. AGE (In years last birthday) <b>49</b><br>If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>                             |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>              | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>George Pearce</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                    |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Mariano Bisese, 1030 W. Barre Street</b>  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. <b>171X</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of Cervix and uterus</b><br>(A) DUE TO<br>ANTECEDENT CAUSES<br>(B) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                                    |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |  | 22. I hereby certify that I attended the deceased from <b>Sept</b> , 19 <b>50</b> , to <b>July 27</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 27</b> , 19 <b>53</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above. |  |   |  |
| 23A. SIGNATURE<br><b>John P. Wilcock Jr.</b>  |  | 23B. ADDRESS<br><b>1227 Waver Blvd</b>  |  | 23C. DATE SIGNED<br><b>7-29 53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 24B. DATE<br><b>7/31/53</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>                                       |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Huntington Williams, M.D. &amp; M. Cook, Inc., 1217 St. Paul Street</b>  |  |   |  |

100 600

100 600

July 27, 48

James I. Haggard

Barry

James I. Haggard

Barry

Barry

Barry

Barry

Barry

Barry

Barry

Barry

Barry

Barry

Barry

100

100 600

James I. Haggard

Barry

Barry

100 600

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 6878

AB-103861  
53 6878

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James H. Gilland

2. DATE  
OF  
DEATH

July 27-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)Baltimore City Hospitals  
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

C. Length of stay in Baltimore

41yrs

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

4940 Eastern Ave., Baltimore City Hospital

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Oct. 19-1869

9. AGE (In years  
last birthday)

83

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Ret. Stone Mason

10B. KIND OF BUSINESS OR  
INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David Gilland

14. MOTHER'S MAIDEN NAME

Mary Crosby

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT 4940 Eastern Ave. APRESS  
Records: Baltimore City Hospitals

18.

527.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Emphysema

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-3-1947, to 7-27-1953, that I last saw the  
deceased alive on 7-27-1953, and that death occurred at 7.55PM, from the causes and on the date stated above.

23A. SIGNATURE

H. John New

M. D.

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

7-27-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/30/53

24C. NAME OF CEMETERY OR CREMATORY

Hiss Methodist Cemetery

24D. LOCATION (City, town, or county)

Harford Road,

(State)

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook &amp; Co., 1217 St. Paul Street

CONFIDENTIAL  
WINTER

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6879  
Registered No. 53 6879

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Adina Benjamin Webb

2. DATE  
OF  
DEATHJuly 28  
1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION3732 OLD FREDERICK  
ROAD

C. Length of stay in Baltimore

33

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

20-07

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3732 OLD FREDERICK ROAD

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JANUARY 15  
18789. AGE (In years  
last birthday)

75

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES Henry Mundie

14. MOTHER'S MAIDEN NAME

SUSAN ELLEN Kuntz Field

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MRS Adelaide Gageby 3732 OLD FRED  
RD.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Hypertensive Cardio-Vascular  
Disease

10 years

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Senility

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1949, to July 28, 1953, that I last saw the  
deceased alive on July 27, 1953, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Borden

23B. ADDRESS

5000 Old Frederick Road

23C. DATE SIGNED

7/28/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/30/53

24C. NAME OF CEMETERY

Meadowridge

24D. LOCATION (City, town, or county)

Dorsey, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc., 1217 S. Paul St

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE

RECORDS

OF THE

71

UNITED STATES DEPARTMENT OF JUSTICE  
INVESTIGATION OF THE  
RECORDS  
OF THE

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INVESTIGATION OF THE  
RECORDS  
OF THE



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6880

BIRTH NO. 53 6880

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GERALD WARD WATERMAN</b>                                       |                                  |   | 2. DATE OF DEATH<br><b>July 23, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Virginia</b> B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Morgue</b>                                  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Norfolk</b>                              |  |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  |   | D. STREET ADDRESS (If rural, give location)   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><b>7/26/94</b>  | 9. AGE (In years last birthday)<br><b>59</b> | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                  | 10B. KIND OF BUSINESS OR INDUSTRY               | 11. BIRTHPLACE (State or foreign country)<br><b>Vermont</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                                |
| 13. FATHER'S NAME<br><b>Albert W. Waterman</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Lenora Darnon</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY NO.                         | 17. INFORMANT<br><b>Biles Funeral Home</b>  |  |   |

|   |                |                                  |
|---|----------------|----------------------------------|
| 18. <b>E 929.8 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Drowning</b><br>DUE TO | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO  |                |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C)</b>   |                |                                  |

|  |                             |   |  |  |  |
|--|-----------------------------|---|--|--|--|
| 19A. DATE OF OPERATION   |                             | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>harbor</b>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Pier 5-Pratt Street</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>July 23, 1953 found P.m.</b>   |                             | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>Apparently fell from dock into water autopsy</b>                      |  |
| 22. I certify that I took charge of the remains described above, held an _____ thereon and from _____ the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                             |   |  |  |  |
| 23A. SIGNATURE<br><b>Joseph A. Jachimsyk</b>   |                             | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 24, 1953</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>7/29/53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Seaside</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Waterford Conn</b>                                 |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 29 1953</b>   |                             | REGISTRAR'S SIGNATURE<br><b>Huntington Hall</b>   |  | 25. FUNERAL DIRECTOR<br><b>Paul St</b>   |  |

1941

OFFICE OF THE  
COMMISSIONER OF THE  
REVENUE

1941

REVENUE DEPARTMENT

1941

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1941

1941

1941

M-245

53 6881

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6881  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eleanor Mc Mullen

2. DATE OF DEATH  
July 27-53

3. PLACE OF DEATH:

Baltimore City, Maryland - Baltimore Md.

4. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Little Sisters of Poor4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Md.  
B. COUNTY Balt.

5. LENGTH OF STAY IN BALTIMORE 4 Yrs. Mos. Days

6. COLOR OR RACE white  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
9. KIND OF BUSINESS OR INDUSTRY

10. FATHER'S NAME

Alexander Mc Fadden

11. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
12. SOCIAL SECURITY NO.13. DATE OF BIRTH 1885  
14. AGE (In years last birthday) 65  
15. If Under 1 Year Months: Days  
16. If Under 24 Hours Hours: Min.17. BIRTHPLACE (State or foreign country) Maryland  
18. CITIZEN OF WHAT COUNTRY?

19. MOTHER'S MAIDEN NAME Mary Mc Gee

20. INFORMANT Little Sisters of the Poor  
21. ADDRESS18. 422.1 I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
2. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 month

5 yrs

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)  
23. INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 15, 1953 to July 27, 1953 that I last saw the deceased alive on July 25, 1953, and that death occurred at 8:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

26. FUNERAL DIRECTOR

ADDRESS

JUL 29 1953

Huntington Williams, M.D. 1631 E North Ave Baltimore Reto Wiedefeld 900 E. Biddle St



3-462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 53-6882

|   |                        |  |                                   |
|---|------------------------|--|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)  |                        | 2. DATE OF DEATH   |                                   |
| Glorioso, Baby Boy  |                        | July 28, 1953  |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |                                   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR NURSING HOME St. Joseph's   |                        | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 26-01            |                                   |
| E. Length of stay in Baltimore 1 da.  |                        | D. STREET ADDRESS (If rural, give location)<br>4207 Bayonne Avenue   |                                   |
| 5. SEX<br>M.  | 6. COLOR OR RACE<br>W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single  | 8. DATE OF BIRTH<br>July 28, 1953 |
| 9. AGE (In years last birthday)   |                        | 10. CITIZEN OF WHAT COUNTRY?   |                                   |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |                        | 12. CITIZEN OF WHAT COUNTRY?<br>U. S.  |                                   |
| 13. FATHER'S NAME<br>Charles A. Glorioso  |                        | 14. MOTHER'S MAIDEN NAME<br>Carmella Rinaldi   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>No   |                        | 16. SOCIAL SECURITY NO.<br>None  |                                   |
| 17. INFORMANT<br>Father   |                        | ADDRESS<br>SAME  |                                   |
| 18. CAUSE OF DEATH  |                        |  |                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>761.0 1 Premature Separation of Placenta |                        |  |                                   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |                        |  |                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                        |  |                                   |
| 19A. DATE OF OPERATION  |                        | 19B. MAJOR FINDINGS OF OPERATION   |                                   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        |  |                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |                        | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                  |                                   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                        | 21D. HOW DID INJURY OCCUR?   |                                   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR AT HOME <input type="checkbox"/>   |                        | 21F. HOW DID INJURY OCCUR?   |                                   |
| 22. I hereby certify that I attended the deceased from July 28, 1953 to July 28, 1953 that I last saw the deceased alive on July 28, 1953, and that death occurred at 2:05a.m., from the causes and on the date stated above.               |                        |  |                                   |
| 23A. SIGNATURE<br>J. N. Nofari  |                        | 23B. ADDRESS<br>1400 N. Caroline Street  |                                   |
| 23C. DATE SIGNED<br>July 29, 1953   |                        |  |                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                        | 24B. DATE<br>July 29 1953  |                                   |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |                        | 24D. LOCATION (City, town, or county)<br>BALTO Md  |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 29 1953   |                        | REGISTRAR'S SIGNATURE<br>Huntington Williams   |                                   |
| 25. FUNERAL DIRECTOR<br>Leonard J. Ruck   |                        | ADDRESS<br>5305 Harford  |                                   |

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
WASHINGTON, D. C.

REPORT OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DIVORCE

DATE OF RE-MARRIAGE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DIVORCE

DATE OF RE-MARRIAGE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT



2100

## BALTIMORE CITY HEALTH DEPARTMENT

## F.W. CERTIFICATE OF DEATH

Registered No. 6883

6883

|   |   |   |   |
|---|---|---|---|
| NAME OF DECEASED<br>(Name or Print) <b>Leopold Pahl</b>   |   | 2. DATE OF DEATH <b>7-28-53</b>   |   |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Leopold Pahl</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-16</b>                      |   |
| Length of stay in Baltimore<br>Yrs. Mos. Days   |   | D. STREET ADDRESS (If rural, give location)<br><b>2921 Virginia Ave #15</b>   |   |
| SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  | 8. DATE OF BIRTH <b>Aug 4 1881</b>                                |
| 9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired) <b>Retired Navy</b>  |   | 10. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>71</b>                         |
| FATHER'S NAME <b>Z</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>Germany</b>  | 12. CITIZEN OF WHAT COUNTRY?                                      |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |   | 14. MOTHER'S MAIDEN NAME <b>Z</b>   | 17. INFORMANT ADDRESS <b>MRS. Margaret Pahl - Virginia 2921</b>   |
| 16. SOCIAL SECURITY NO.   |   | 18. CAUSE OF DEATH<br><b>Acute Myocardial Infarction</b><br><b>Right Pyelonephritis</b><br><b>Right Renal Calculus</b>      |   |
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>7-26-53</b> 19__, to <b>7-28-53</b> 19__, that I last saw the deceased alive on <b>7-28-53</b> 19__, and that death occurred at <b>520A</b> on the date stated above. |   |   |   |
| 23A. SIGNATURE <b>Harold L. Daly Jr.</b>  | 23B. ADDRESS <b>Leopold Pahl</b>  | 23C. DATE SIGNED <b>7-28-53</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 24B. DATE <b>7-31-53</b>  | 24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>   | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b> |
| 25. FUNERAL DIRECTOR <b>Leonard J. Luck</b>   | ADDRESS <b>5305 Harford</b>   |   |   |

59591

STATE OF TEXAS  
COUNTY OF DALLAS

1917

11

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

H-536  
53 6884BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6884

BIRTH NO.

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Arthur J. Hendrickson</b>  |                                  |   | 2. DATE OF DEATH <b>July 28/53</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>21-02</b>   |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>1172 Sargent St</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |  |
| c. Length of stay in Baltimore <b>70</b> Yrs. Mes. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1172 Sargent St</b>   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Sept. 17, 1880</b>   | 9. AGE (In years last birthday)<br><b>72</b>                 | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchman</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Ellicott Machine Shop</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  |   | 13. FATHER'S NAME<br><b>Orien Hendrickson</b>   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |
| 16. SOCIAL SECURITY NO.  |                                  |   | 17. INFORMANT (WIFE) ADDRESS<br><b>Bertha Hendrickson, 1172 Sargent St</b>  |  |  |
| 18. <b>422.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Heart Failure</b><br>DUE TO<br><b>Chronic Myocarditis</b><br>DUE TO<br><b>Atherosclerosis</b><br>DUE TO<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| 19A. DATE OF OPERATION   |                                  |   | 19B. MAJOR FINDINGS OF OPERATION  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  |   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |   | 22. I hereby certify that I attended the deceased from <b>Jan 11, 1953</b> to <b>July 28, 1953</b> , that I last saw the deceased alive on <b>7/25, 1953</b> , and that death occurred at <b>10 45 P.M.</b> , from the causes and on the date stated above. |  |  |
| 23A. SIGNATURE<br><b>Louise</b>  |                                  |   | 23B. ADDRESS<br><b>2730 N Charles</b>   |  |  |
| 23C. DATE SIGNED<br><b>7/29/53</b>   |                                  |   | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |
| 24B. DATE<br><b>Aug 1/53</b>   |                                  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park</b>  |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>  |                                  |   | 25. FUNERAL DIRECTOR<br><b>Harry H. Kuntze</b>  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>9/12/53</b>   |                                  |   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  |  |
| ADDRESS<br><b>4101 Edmondson Ave</b>   |                                  |   | VS 150<br><b>763 3L</b>   |  |  |

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

|                            |  |                          |  |                            |  |
|----------------------------|--|--------------------------|--|----------------------------|--|
| 1. Name of deceased        |  | 2. Sex                   |  | 3. Age                     |  |
| 4. Date of death           |  | 5. Time of death         |  | 6. Place of death          |  |
| 7. Cause of death          |  | 8. Manner of death       |  | 9. Signature of physician  |  |
| 10. Signature of registrar |  | 11. Signature of coroner |  | 12. Signature of jury      |  |
| 13. Signature of witnesses |  | 14. Signature of family  |  | 15. Signature of neighbors |  |
| 16. Signature of clergy    |  | 17. Signature of school  |  | 18. Signature of employer  |  |
| 19. Signature of others    |  | 20. Signature of others  |  | 21. Signature of others    |  |
| 22. Signature of others    |  | 23. Signature of others  |  | 24. Signature of others    |  |
| 25. Signature of others    |  | 26. Signature of others  |  | 27. Signature of others    |  |
| 28. Signature of others    |  | 29. Signature of others  |  | 30. Signature of others    |  |
| 31. Signature of others    |  | 32. Signature of others  |  | 33. Signature of others    |  |
| 34. Signature of others    |  | 35. Signature of others  |  | 36. Signature of others    |  |
| 37. Signature of others    |  | 38. Signature of others  |  | 39. Signature of others    |  |
| 40. Signature of others    |  | 41. Signature of others  |  | 42. Signature of others    |  |
| 43. Signature of others    |  | 44. Signature of others  |  | 45. Signature of others    |  |
| 46. Signature of others    |  | 47. Signature of others  |  | 48. Signature of others    |  |
| 49. Signature of others    |  | 50. Signature of others  |  | 51. Signature of others    |  |
| 52. Signature of others    |  | 53. Signature of others  |  | 54. Signature of others    |  |
| 55. Signature of others    |  | 56. Signature of others  |  | 57. Signature of others    |  |
| 58. Signature of others    |  | 59. Signature of others  |  | 60. Signature of others    |  |
| 61. Signature of others    |  | 62. Signature of others  |  | 63. Signature of others    |  |
| 64. Signature of others    |  | 65. Signature of others  |  | 66. Signature of others    |  |
| 67. Signature of others    |  | 68. Signature of others  |  | 69. Signature of others    |  |
| 70. Signature of others    |  | 71. Signature of others  |  | 72. Signature of others    |  |
| 73. Signature of others    |  | 74. Signature of others  |  | 75. Signature of others    |  |
| 76. Signature of others    |  | 77. Signature of others  |  | 78. Signature of others    |  |
| 79. Signature of others    |  | 80. Signature of others  |  | 81. Signature of others    |  |
| 82. Signature of others    |  | 83. Signature of others  |  | 84. Signature of others    |  |
| 85. Signature of others    |  | 86. Signature of others  |  | 87. Signature of others    |  |
| 88. Signature of others    |  | 89. Signature of others  |  | 90. Signature of others    |  |
| 91. Signature of others    |  | 92. Signature of others  |  | 93. Signature of others    |  |
| 94. Signature of others    |  | 95. Signature of others  |  | 96. Signature of others    |  |
| 97. Signature of others    |  | 98. Signature of others  |  | 99. Signature of others    |  |
| 100. Signature of others   |  | 101. Signature of others |  | 102. Signature of others   |  |

53 6885

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6885

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John or Bogumil Danielczyk (Daniels)

2. DATE  
OF  
DEATH

July 27th, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland 6729 Youngstown Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

At Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 22,

26-36

D. STREET ADDRESS (If rural, give location)

6729 Youngstown Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

White

7. SINGLE. MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 16, 1878

9. AGE (In years  
last birthday)

75 yrs.

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Tender Repairman

10B. KIND OF BUSINESS OR  
INDUSTRY

Pennsylvania R. R. Co.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

717-07-6991

17. INFORMANT

ADDRESS

Feliksa Danielczyk 6729 Youngstown Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

CARCINOMA OF RECTUM

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

JULY 12, 1951

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA OF RECTUM

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 3, 1951, to JULY 27, 1953, that I last saw the  
deceased alive on July 26, 1953, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1218 N. Calvert St. Balto. Md. 28 July 53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 31, 1953

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Mary

24D. LOCATION (City, town, or county) (State)

German Hill Road Baltimore,

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D.

George A. Weber 705 S. Anna St

DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS

STATE OF NEW YORK  
COUNTY OF [ ]

IN SENATE  
JANUARY 1, 1900

REPORT OF THE  
COMMISSIONER OF HEALTH

FOR THE YEAR 1899

ALBANY: J. B. LIPPINCOTT & CO.,  
PRINTERS, 1899.

THE STATE OF NEW YORK  
OFFICE OF THE COMMISSIONER OF HEALTH  
ALBANY, N. Y.

REPORT OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR 1899

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OFFICE OF THE COMMISSIONER OF HEALTH  
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PRINTERS, 1899.

THE STATE OF NEW YORK  
OFFICE OF THE COMMISSIONER OF HEALTH  
ALBANY, N. Y.



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MAF-169937

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6886  
Registered No.

BIRTH NO. 53 6886

1. NAME OF DECEASED  
(Type or Print)

Frank N. Gosid

2. DATE  
OF

DEATH July 27, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

AA

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Severna Park

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

1

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 12, 1870

9. AGE (In years  
last birthday)

82

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank? Gzyzowski

14. MOTHER'S MAIDEN NAME

Elizabeth?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 331X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

Cerebral Vascular Accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Hypertensive Cardio  
Vascular Disease . Senility.

19A. DATE OF OPERATION

5-18-53

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Amputation Rt. Leg

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-29, 1953 to 7-27, 1953, that I last saw the  
deceased alive on 7-27, 1953, and that death occurred at 7:30P.m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. G. [Signature]

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

7-27-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-30-1953

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, town, or county)

Dundock Ave. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

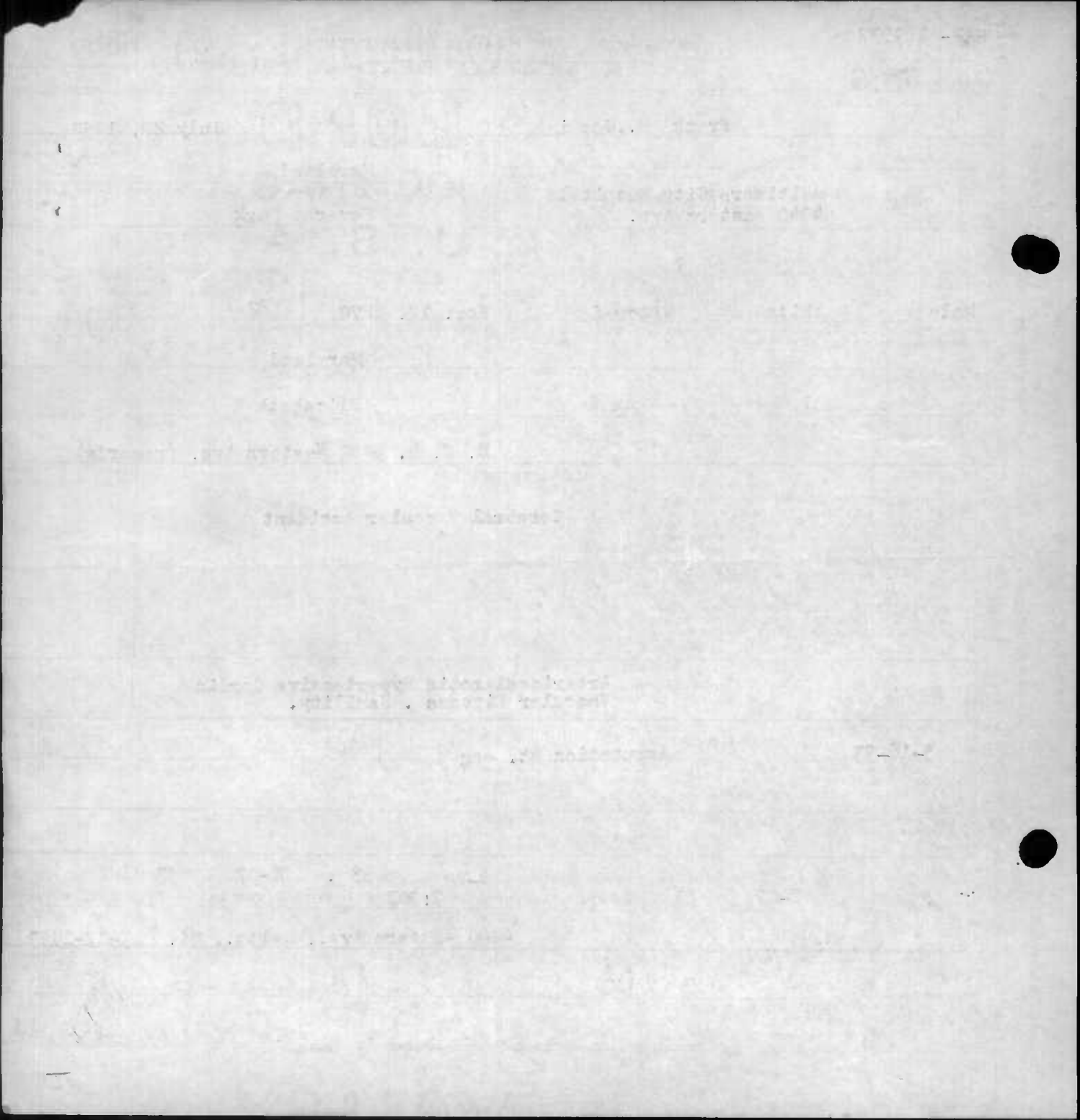
H. J. G. [Signature]

25. FUNERAL DIRECTOR

ADDRESS

John J. Duda Jr. 2829 E. 1st St.

VS 150



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 53 6887

53 6887  
BIRTH NO.

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Thomas Smith H.</u>   |                                     | <b>2. DATE OF DEATH</b><br><u>7-27-53</u>  |  |
| <b>3. PLACE OF DEATH:</b><br><b>A. Baltimore City, Maryland</b><br><b>B. FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>Providence Hospital</u><br><b>C. Length of stay in Baltimore</b> <u>Life</u>                          |                                     | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)<br><b>A. STATE</b> <u>Md</u> <b>B. COUNTY</b> <u>17-02</u><br><b>C. CITY OR TOWN</b> <u>Balto</u><br><b>D. STREET ADDRESS</b> (If rural, give location) <u>614 W. Hoffman St.</u> |  |
| <b>5. SEX</b><br><u>M</u>  | <b>6. COLOR OR RACE</b><br><u>C</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b><br><u>M</u>   | <b>8. DATE OF BIRTH</b><br><u>12/27/97</u> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Porter</u>  |                                     | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>—</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>Virgil Smith</u>  |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><u>—</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>Yes</u><br>(If yes, give war or dates of service) <u>WW # 1</u>   |                                     | <b>16. SOCIAL SECURITY NO.</b><br><u>—</u>   |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>331X I</u> |                                     | <b>CAUSE OF DEATH</b><br><b>(A)</b> <u>Cerebral Vascular</u><br><b>QUE TO</b> <u>Accident.</u><br><b>(B)</b> <u>—</u><br><b>QUE TO</b> <u>—</u><br><b>(C)</b> <u>—</u>   |  |

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

|  |  |   |
|--|--|---|
| <b>19A. DATE OF OPERATION</b><br><u>2</u>                          | <b>19B. MAJOR FINDINGS OF OPERATION</b><br><u>—</u>  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| <b>21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)</b><br><u>—</u>      | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>—</u>      | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br><u>—</u> |
| <b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b><br><u>—</u> | <b>21E. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>21F. HOW DID INJURY OCCUR?</b><br><u>—</u>   |

**22. I hereby certify that I attended the deceased from July 27, 1953, to July 27, 1953, that I last saw the deceased alive on 7/27, 1953, and that death occurred at 8:30 P.M., from the causes and on the date stated above.**

|   |   |   |
|---|---|---|
| <b>23A. SIGNATURE</b><br><u>[Signature]</u> | <b>23B. ADDRESS</b><br><u>2530 - Pa. Ave.</u> | <b>23C. DATE SIGNED</b><br><u>7/28/53</u> |
|---|---|---|

|   |  |   |   |
|---|--|---|---|
| <b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u> | <b>24B. DATE</b><br><u>7/30/53</u>                 | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><u>Balto. Nat.</u> | <b>24D. LOCATION (City, town, or county) (State)</b><br><u>Balto. Md.</u> |
| <b>DATE RECEIVED BY LOCAL REGISTRAR</b><br><u>JUL 29 1953</u>     | <b>REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u> | <b>25. FUNERAL DIRECTOR</b><br><u>Helen H. Kelson</u>           | <b>ADDRESS</b><br><u>1303 78099 Presstman St.</u>                         |

MEDICAL CERTIFICATION

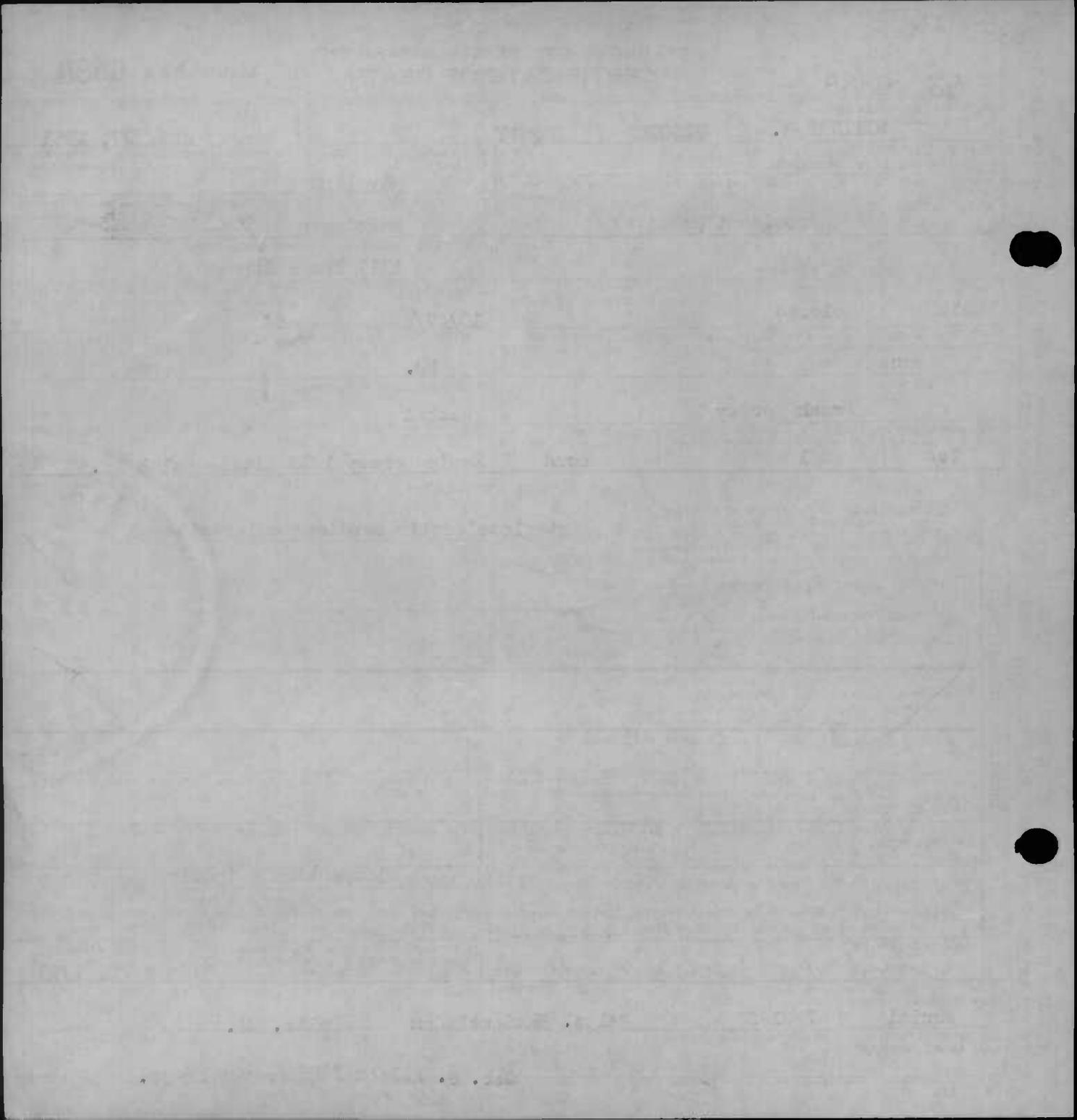
THE NATIONAL BUREAU OF HEALTH  
DEPARTMENT OF HEALTH



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. <sup>53</sup> 6888

BIRTH No. 6888

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM E. <del>MURPHY</del> DORSEY</b>   |   |  | 2. DATE OF DEATH<br><b>July 27, 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Provident Hospital</b>  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>15-02</b>                  |   |  |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>1317 Bruce Street</b>  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>                  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>  | 8. DATE OF BIRTH<br><b>10/27/86</b>  |   | 9. AGE (In years last birthday)<br><b>66</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Frank Dorsey</b>  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rachel</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>   | 17. INFORMANT ADDRESS<br><b>Essie Dorsey 1633 Little Walsh St.</b>   |   |  |
| 18. <b>422.1</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO<br><b>(C)</b>                           |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |  |   |  |
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   | 21E. INJURY OCCURRED<br>M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |  |  |   |  |
| 23A. SIGNATURE<br><b>Joseph A. Jachimczyk</b> M.D.  |   | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 28, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>7/31/53</b>                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cem</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>Geo. G. Kelson 1303 Presstman St.</b>   |   | ADDRESS<br><b>Geo. G. Kelson</b>             |





M-240

53 6889

# LEROY MAKEL BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 53 6889

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *Leroy Machel*2. DATE OF DEATH *7-26-53*3. PLACE OF DEATH: *Provident Hospital*  
A. Baltimore City, MarylandB. FULL NAME OF HOSPITAL OR INSTITUTION *Provident Hospital*4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *BALTIMORE, MD.* B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *BALTIMORE 14-03*D. STREET ADDRESS (If rural, give location) *7012 Division St.*c. Length of stay in Baltimore *44*Yrs.  
Mos.  
Days5. SEX *M*6. COLOR OR RACE *C*7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *M*8. DATE OF BIRTH *Aug. 26, 1908*9. AGE (In years last birthday) *44*

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Porter*10B. KIND OF BUSINESS OR INDUSTRY *Apt. House*11. BIRTHPLACE (State or foreign country) *Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Joseph Machel*14. MOTHER'S MAIDEN NAME *Bertha A. Houston*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT *Wife*ADDRESS *SAME*18. *002 X I*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *ACUTE respiratory failure*  
DUE TO *Far advance P.T.B.**one hour and 15 minutes*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertensive disease*  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *No op*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

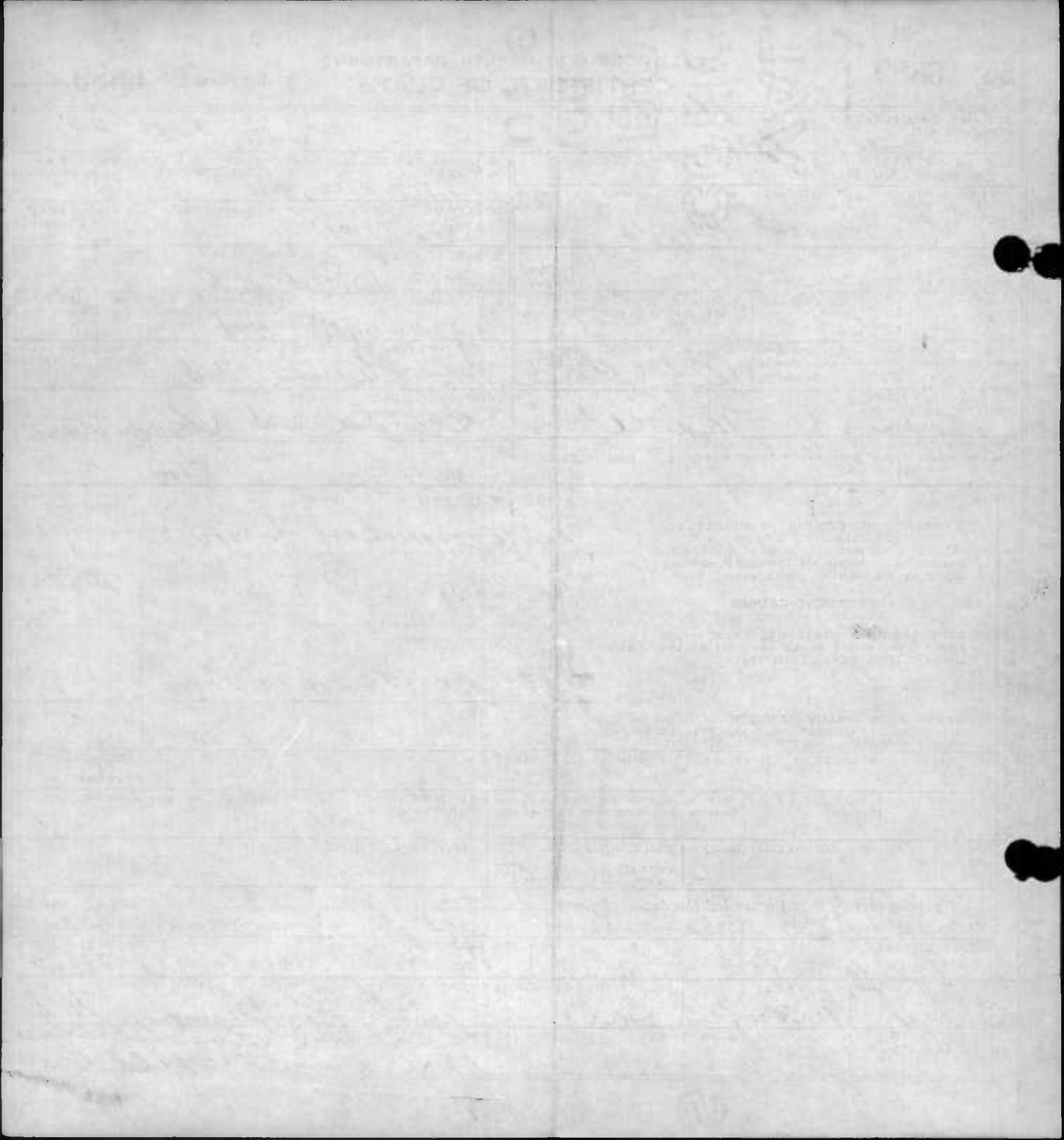
22. I hereby certify that I attended the deceased from *7-26, 1953* to *7-26, 1953*, that I last saw the deceased alive on *7-26, 1953*, and that death occurred at *2:20* m., from the causes and on the date stated above.23A. SIGNATURE, *Dr. O. de la Cruz*

M. D.

23B. ADDRESS *Provident Hospital*23C. DATE SIGNED *7-27-53*24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*24B. DATE *7-30-1953*24C. NAME OF CEMETERY OR CREMATORY *Bald. National*24D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE *Huntington Williams*25. FUNERAL DIRECTOR *Funeral Home*ADDRESS *1631 Daniel Hill Ave*



2-435

53 6880

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6880  
12 2

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary F Goldmar

2. DATE  
OF  
DEATH

7/25-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1446 N. Carey St.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

40 yrs

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

1446 Carey

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Balto Md 1501

D. STREET ADDRESS (If rural, give location)

1446 Carey

8. DATE OF BIRTH

Sept. 11, 1892

9. AGE (In years last birthday)

60

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Custodian

10B. KIND OF BUSINESS OR INDUSTRY

Church

11. BIRTHPLACE (State or foreign country)

Gardner, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Turner Kaywood

14. MOTHER'S MAIDEN NAME

Lucinda Dickens

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

Yes, no or unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

1446 N. Carey St.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

DUE TO

Recurrent Carcinoma  
Rectum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/22, 1953, to 7/25, 1953, that I last saw the deceased alive on 7/25, 1953, and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

Barker

23B. ADDRESS

M. D.

2135 V. St.

23C. DATE SIGNED

7/25, 53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 29 1953

Huntington Williams

26. FUNERAL HOME

VS 150

7708W



0-356  
53 6891BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6891  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John O'Connor

2. DATE  
OF  
DEATH

7/29/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived: If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

St. Agnes Hospital

C. CITY OR TOWN

BALTIMORE 13-07

D. STREET ADDRESS (If rural, give location)

804 W. 37th. St

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

AUG 26, 1883

9. AGE (In years  
last birthday)

69

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RETIRED PIANO TUNER

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MARTIN O'CONNOR

14. MOTHER'S MAIDEN NAME

HANNAH ROCHE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ELIZABETH O'CONNOR - 804 W 37<sup>th</sup> ST

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Vascular Accident

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/28/53, 19\_\_, to 7/29/53, 19\_\_, that I last saw the  
deceased alive on 7/29/53, 19\_\_, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23. SIGNATURE

B. Martin Middleton

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

7/29/53

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

Aug 1/53

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Old Frederick Rd Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Austin E. Donoran 3818 Roland Ave

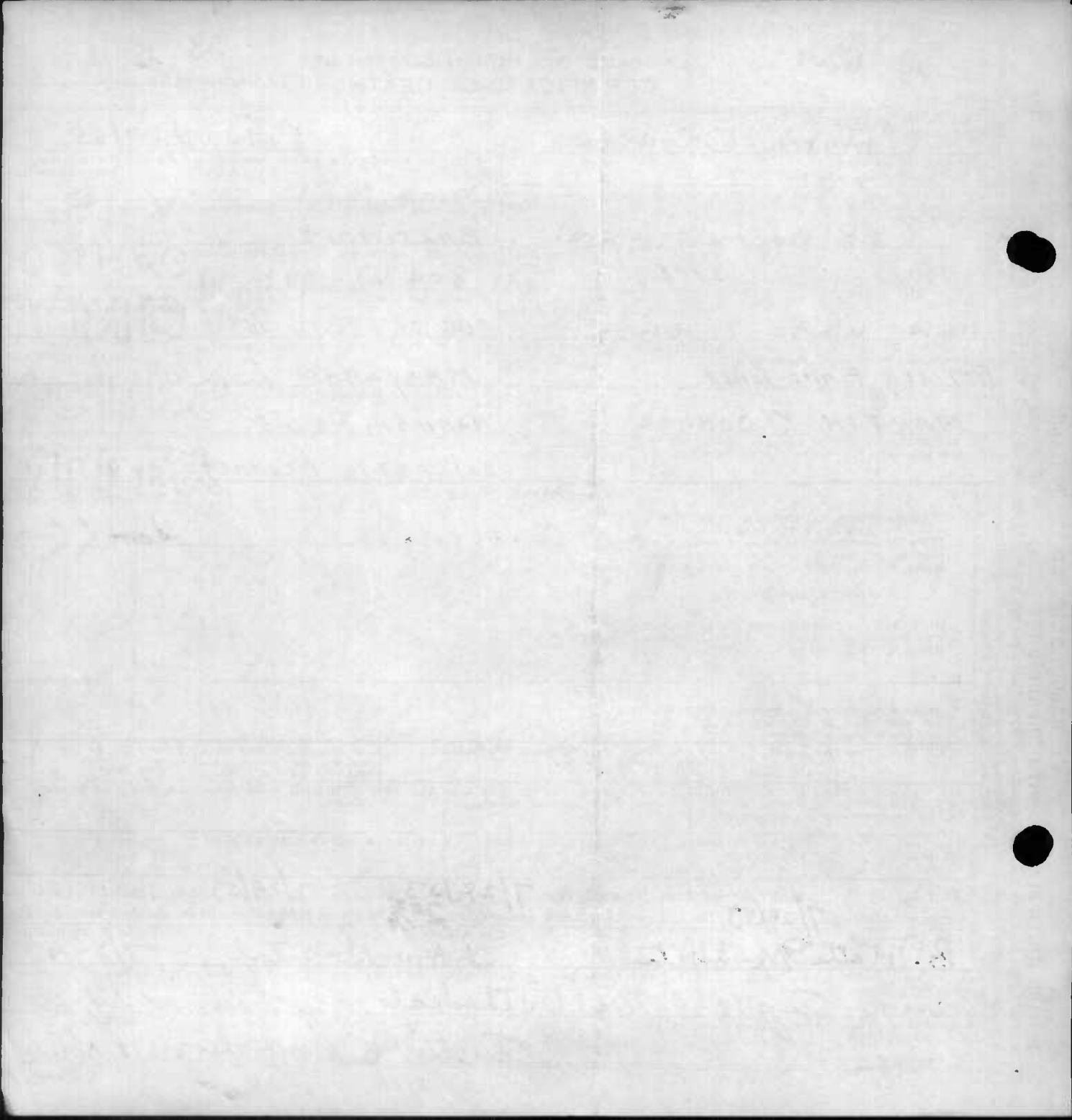
ADDRESS

JUL 29 1953  
VS 150

57284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





G-536  
53 6892BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6892  
Registered No.

RTH NO.

NAME OF DECEASED  
(Type or Print)

Margaret M. Gunther

2. DATE  
OF  
DEATH

7-27-53

PLACE OF DEATH:

Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

FULL NAME OF (If not in hospital or institution, give street address or  
location)HOSPITAL OR  
STITUTION

3011 Eastern Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto - Md. 1-02

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3011 Eastern Ave

SEX

F-

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOW, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12-4-81

9. AGE (in years  
last birthday)

72

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.A. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto - Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

FATHER'S NAME

Nicholas Gunther

14. MOTHER'S MAIDEN NAME

Margaret ?

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles Gunther

same

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office hldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1953, to 7/27, 1953, that I last saw the  
deceased alive on 7/27, 1953 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Tanberg M.D.

23B. ADDRESS

4418 Ellwood Ave

23C. DATE SIGNED

A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8-1-53

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto - Md.

(State)

RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zilberich - 403 S. Wolfe  
St.

CERTIFICATE OF DEATH

BIRMINGHAM CITY HEALTH DEPARTMENT

For my -  
Edward A. ...

V-656 6893

53 6893

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

TH NO. \_\_\_\_\_

NAME OF DECEASED  
(Last name or Print)*William J. Warner*2. DATE  
OF  
DEATH*7-28-53*PLACE OF DEATH:  
Baltimore City, MarylandFULL NAME OF  
HOSPITAL OR  
NURSING HOME  
(If not in hospital or institution, give street address or location)*3922 Lyndale Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto - Md 26-03*

D. STREET ADDRESS (If rural, give location)

*3922 Lyndale Ave*

Length of stay in Baltimore

*Life*Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)8. USUAL OCCUPATION (Give kind of  
one during most of working life, even if retired)10a. KIND OF BUSINESS OR  
INDUSTRY

9. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.*4-22-66**67*

11. BIRTHPLACE (State or foreign country)

*Baltimore -*12. CITIZEN OF  
WHAT COUNTRY?*U.S.A.*

FATHER'S NAME

*John Warner*

14. MOTHER'S MAIDEN NAME

*Caroline Lanterbach*WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Mary Warner**same*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

*Coronary occlusion*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

*Coronary Sclerosis  
myocardial infarction*

(C)

11

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.*Cardiac Hypertrophy-Arteriosclerosis*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
shoot home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from *July 4, 1953*, to *July 28, 1953*, that I last saw the  
deceased alive on *July 25, 1953*, and that death occurred at *6:30 AM*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial**8-1-53**Holy Redeemer**Balto - Md*RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*William J. Warner**Lilly & John 403 S. Wolfe*

VS 150

682 93

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE

January 1, 1910

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1909

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1910

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

ALBANY

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C-500  
53 6894BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

COONEY

53 6894  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nelson J. Cooney

2. DATE  
OF  
DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)

Mercy Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

486 Brunswick Rd #25

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John C. Cooney Jr. 3112 Howard Drive

18. 153X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pulmonary edema

6 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Abdominal carcinoma

2 yrs

(C)

Ca colon

2725-

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 5, 1953, to July 28, 1953, that I last saw the  
deceased alive on July 28, 1953, and that death occurred at 1:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

77382

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

1914

420

1914

1914



S-315  
53 6895BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH 421.4

Registered No. ....

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

501 Buren St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

John Steponski (STEFANSKI)

3 (b) If veteran, name war

3 (c) Social Security Account

No. 219-05-6399

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JUNE

8. AGE: Years Months Days

49

If less than one day

hr. min.

9. Birthplace

BALTO

MD

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

TRAIN ELEVATOR

FATHER

12. Name

JOHN STEFANSKI

13. Birthplace

?

MOTHER

14. Maiden Name

MARY KUFOWA

15. Birthplace

?

16 (a) Informant

FRANK STEFANSKI

Address

2003 S. NEWKIRK ST

17 (a)

BURIAL

(b) Date thereof

JULY 30/53

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

ST. STANISLAUS CEM

Location

DUN PALK AVE

18 (a) Funeral director

STEPHEN J. FIALKOWSKI

(b) Address

1006 S. KENWOOD AVE

19 (a)

(b) Date registered by registrar

Huntington Williams, M.D.

Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Balto. 76-36

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2003 S. Newkirk St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27

1953, 12:05 PM

21. I certify that death occurred on the date above stated, that I attended

deceased from 7/27 1953, to 7/27 1953

and that I last saw him alive on 7/27 1953.

Immediate cause of death

cardiac failure

Due to

myocarditis  
endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. M. Murphy

Address

501 Buren St

Date signed

7/28/53

7007 Leet St.

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



CERTIFICATE OF DEATH

|                            |  |                            |  |                           |  |
|----------------------------|--|----------------------------|--|---------------------------|--|
| 1. Name of deceased        |  | 2. Sex                     |  | 3. Age                    |  |
| 4. Date of death           |  | 5. Time of death           |  | 6. Place of death         |  |
| 7. Cause of death          |  | 8. Manner of death         |  | 9. Signature of physician |  |
| 10. Signature of registrar |  | 11. Signature of informant |  | 12. Date of registration  |  |

14520  
53 6897

53 6897

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Henneke, Elizabeth Lorena

2. DATE

OF

DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

St. Joseph's

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3104 E. McElderry Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 25, 1892

9. AGE (In years last birthday)

61

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hwfe.

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frederick White

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Frank Henneke - 3104 E. McElderry St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auto hemorrhagic anemia

DUE TO

7/22-7/28

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Esophageal varices

DUE TO

5/2-7/28

(C) Cirrhosis of liver

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1953 to July 28, 1953, that I last saw the deceased alive on July 28, 1953, and that death occurred at 1:44pm from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1400 N. Caroline Street

July 28, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/1/53

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Balto. 17, Md.

CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <p>1. Name of deceased: _____</p>      |  | <p>2. Sex: _____</p>                     |  | <p>3. Age: _____</p>                     |  |
| <p>4. Date of death: _____</p>         |  | <p>5. Time of death: _____</p>           |  | <p>6. Place of death: _____</p>          |  |
| <p>7. Cause of death: _____</p>        |  | <p>8. Immediate cause: _____</p>         |  | <p>9. Contributing cause: _____</p>      |  |
| <p>10. Manner of death: _____</p>      |  | <p>11. Signature of physician: _____</p> |  | <p>12. Signature of registrar: _____</p> |  |
| <p>13. Date of registration: _____</p> |  | <p>14. Office of registration: _____</p> |  | <p>15. District of Columbia: _____</p>   |  |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Roy M. Berrett

2. DATE  
OF  
DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY BALTO.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

D.O.A. Bons Secours Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Catonsville

D. STREET ADDRESS (If rural, give location)  
5426 Channing Road

Length of stay in Baltimore 27 yrs.

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Sept. 12, 1900

9. AGE (In years  
last birthday)

52

# Under 1 Year  
Months: Days

# Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Yardmaster

10B. KIND OF BUSINESS OR  
INDUSTRY

B.&O. R.R.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Berrett

14. MOTHER'S MAIDEN NAME

Fuchs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS  
Delores Biddington 5428 Channing Road

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

1 hour

QUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

QUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to July 28, 1953, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 8:05p m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/31/53

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. Pk.

24D. LOCATION (City, town, or county)

Elkridge, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATEMENT OF DEATH  
CERTIFICATE OF DEATH

|                                   |  |                                 |  |                                 |  |                                   |  |
|-----------------------------------|--|---------------------------------|--|---------------------------------|--|-----------------------------------|--|
| 1. Name of deceased               |  | 2. Sex                          |  | 3. Age                          |  | 4. Date of death                  |  |
| 5. Place of death                 |  | 6. Cause of death               |  | 7. Manner of death              |  | 8. Signature of physician         |  |
| 9. Signature of registrar         |  | 10. Signature of informant      |  | 11. Signature of witness        |  | 12. Signature of coroner          |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker     |  | 15. Signature of cemetery       |  | 16. Signature of church           |  |
| 17. Signature of family           |  | 18. Signature of friends        |  | 19. Signature of neighbors      |  | 20. Signature of community        |  |
| 21. Signature of school           |  | 22. Signature of employer       |  | 23. Signature of business       |  | 24. Signature of government       |  |
| 25. Signature of military         |  | 26. Signature of naval          |  | 27. Signature of air force      |  | 28. Signature of space            |  |
| 29. Signature of intelligence     |  | 30. Signature of defense        |  | 31. Signature of justice        |  | 32. Signature of education        |  |
| 33. Signature of health           |  | 34. Signature of labor          |  | 35. Signature of agriculture    |  | 36. Signature of industry         |  |
| 37. Signature of commerce         |  | 38. Signature of transportation |  | 39. Signature of communication  |  | 40. Signature of energy           |  |
| 41. Signature of environment      |  | 42. Signature of science        |  | 43. Signature of technology     |  | 44. Signature of innovation       |  |
| 45. Signature of culture          |  | 46. Signature of arts           |  | 47. Signature of sports         |  | 48. Signature of recreation       |  |
| 49. Signature of entertainment    |  | 50. Signature of media          |  | 51. Signature of advertising    |  | 52. Signature of public relations |  |
| 53. Signature of marketing        |  | 54. Signature of sales          |  | 55. Signature of distribution   |  | 56. Signature of retail           |  |
| 57. Signature of wholesale        |  | 58. Signature of export         |  | 59. Signature of import         |  | 60. Signature of trade            |  |
| 61. Signature of finance          |  | 62. Signature of banking        |  | 63. Signature of insurance      |  | 64. Signature of investment       |  |
| 65. Signature of real estate      |  | 66. Signature of construction   |  | 67. Signature of engineering    |  | 68. Signature of architecture     |  |
| 69. Signature of design           |  | 70. Signature of manufacturing  |  | 71. Signature of processing     |  | 72. Signature of assembly         |  |
| 73. Signature of packaging        |  | 74. Signature of distribution   |  | 75. Signature of retail         |  | 76. Signature of service          |  |
| 77. Signature of support          |  | 78. Signature of maintenance    |  | 79. Signature of repair         |  | 80. Signature of replacement      |  |
| 81. Signature of disposal         |  | 82. Signature of recycling      |  | 83. Signature of reuse          |  | 84. Signature of repurpose        |  |
| 85. Signature of renovation       |  | 86. Signature of restoration    |  | 87. Signature of reconstruction |  | 88. Signature of reconstruction   |  |
| 89. Signature of reconstruction   |  | 90. Signature of reconstruction |  | 91. Signature of reconstruction |  | 92. Signature of reconstruction   |  |
| 93. Signature of reconstruction   |  | 94. Signature of reconstruction |  | 95. Signature of reconstruction |  | 96. Signature of reconstruction   |  |
| 97. Signature of reconstruction   |  | 98. Signature of reconstruction |  | 99. Signature of reconstruction |  | 100. Signature of reconstruction  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| - 615<br>53 6899   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | 53 6899<br>Registered No.   |  |
| NAME OF DECEASED<br>(Print)  |  | MR. JOSEPH REED CARPENTER  |  | 2. DATE OF DEATH<br>7/28/53   |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>MARYLAND  |  | B. COUNTY<br>-  |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br>UNION MEMORIAL HOSP.   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE-18 12-0  |  | D. STREET ADDRESS (If rural, give location)<br>2825 GUILFORD AVE.                   |  |
| 6. COLOR OR RACE<br>W  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>M   |  | 8. DATE OF BIRTH<br>10/28/1896  |  |
| 9. AGE (In years last birthday)<br>56  |  | 10. KIND OF BUSINESS OR INDUSTRY<br>S. S. O. A. B.   |  | 11. BIRTHPLACE (State or foreign country)<br>PENNSYLVANIA                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 14. MOTHER'S MAIDEN NAME<br>ELIZABETH BOWMAN   |  | 17. INFORMANT<br>WIFE   |  |
| 13. FATHER'S NAME<br>Samuel CARPENTER  |  | 15. SOCIAL SECURITY NO.  |  | ADDRESS<br>SAME   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br>yes World War I  |  | 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Cerebrovascular accident<br>DUE TO<br>Hypertensive cardiovascular disease<br>DUE TO<br>Pseudo-polycythemia |  | INTERVAL BETWEEN ONSET AND DEATH<br>36 hrs.<br>?<br>?                               |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |
| 21. DATE OF OPERATION  |  | 22. MAJOR FINDINGS OF OPERATION  |  | 23. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |
| 27. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 29. HOW DID INJURY OCCUR?   |  |
| 30. I hereby certify that I attended the deceased from 7/27, 1953, to 7/28, 1953, that I last saw the deceased alive on 7/28, 1953, and that death occurred at 11:35 P.M., from the causes and on the date stated above. |  |  |  |   |  |
| 31. SIGNATURE<br>Henry S. Adcock, Jr.  |  | 32. ADDRESS<br>Union Memorial Hosp.  |  | 33. DATE SIGNED<br>7/28/53  |  |
| 34. BURIAL, CREMATION, REMOVAL (Specify)<br>removal  |  | 35. DATE<br>7/30/53  |  | 36. NAME OF CEMETERY OR CREMATORY<br>Castle View Cem.                               |  |
| 37. LOCATION (City, town, or county) (State)<br>New Castle, Pa.  |  | 38. RECEIVED BY<br>Huntington Williams, Jr.  |  | 39. REGISTRAR'S SIGNATURE<br>Huntington Williams, Jr.                               |  |
| 40. FUNERAL DIRECTOR<br>J. J. Pickens & Sons   |  | 41. ADDRESS<br>Bucks 17, Md.   |  | 42. VS 150<br>29091   |  |



MARGIN RESERVED FOR BINDING  
PLEASE WRITE PEN ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6900  
Registered No.

BIRTH NO.

|   |                                  |  |                                   |
|---|----------------------------------|--|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Helen C. Perrelli</b>   |                                  | 2. DATE OF DEATH<br><b>1/28/53</b>   |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>New Jersey</b><br>B. COUNTY |                                   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Lodi</b>                                      |                                   |
| c. Length of stay in Baltimore<br><b>13</b> Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>279 Union Street</b>   |                                   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>1/6/00</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Core Maker</b>      |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Casting + Eng. Corp.</b>   |                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>OHio</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                   |
| 13. FATHER'S NAME<br><b>Charles Riedel</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Hetty</b>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY NO.  |                                   |
| 17. INFORMANT<br><b>Frank A. Perrelli</b>   |                                  | ADDRESS<br><b>same</b>   |                                   |

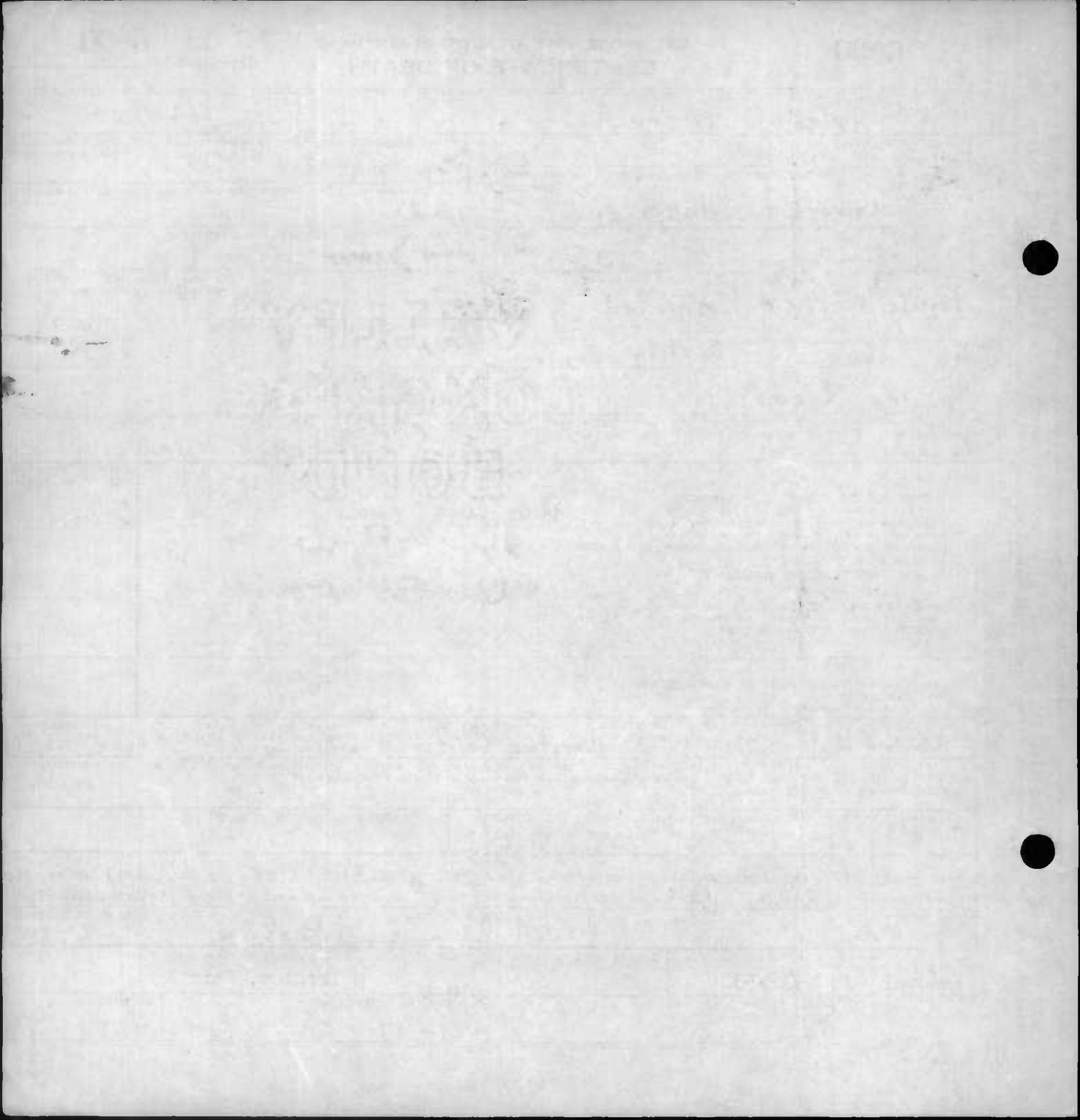
|   |   |  |
|---|---|--|
| 18. <b>572.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Ulcerative colitis</b> | CAUSE OF DEATH<br>(A) <b>Ulcerative colitis</b><br>(B) <b>transverse colectomy</b><br>(C) | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   |  |

|  |   |  |   |
|--|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT. |   |  |   |
| 19A. DATE OF OPERATION<br><b>1/22/53</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ulcerative Colitis</b>                             | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

|   |  |  |  |
|---|--|--|--|
| 22. I hereby certify that I attended the deceased from <b>1/16</b> , 19 <b>53</b> , to <b>1/28</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>1/22</b> , 19 <b>53</b> , and that death occurred at <b>11</b> p.m., from the causes and on the date stated above. |  |  |  |
| 23A. SIGNATURE<br><b>D. R. Riedel</b>   |  | 23B. ADDRESS<br><b>University Hospital</b>                             | 23C. DATE SIGNED<br><b>1-29-53</b>             |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 24B. DATE<br><b>7/29/53</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>I</b> |
| 24D. LOCATION (City, town, or county) (State)<br><b>Ironton, Ohio</b>   |  | 25. FUNERAL DIRECTOR<br><b>Thos. J. Dickner &amp; Sons - Bath 17 M</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>1-29-53</b>  |  | REGISTRAR'S SIGNATURE<br><b>Thos. J. Dickner</b>                       |  |

VS 150

6903D





V-520  
53 6901BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6901

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marie Vanik

2. DATE  
OF  
DEATH

July 26, 1953.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONASBurton Convalescing Home  
3520 Hilton Rd.,

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2433 E. Eager Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct 20, 1898

9. AGE (In years

last birthday)

55

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Frederick Boedeker

14. MOTHER'S MAIDEN NAME

Catherine Berger

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL

SECURITY NO.

214-24-0588

17. INFORMANT

ADDRESS

Thos. Vanik (Husband) 2433 E. Eager Street

18. 334X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Bronchio pneumonia

5 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hemiplegia

3 months

DUE TO

(C)

Cerebral arteriosclerosis

5 yrs.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive C.V. disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/18, 1953 to 7/26, 1953 that I last saw the  
deceased alive on 7/26, 1953 and that death occurred at 8:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Karl Grossman

M. D.

23B. ADDRESS

1212 N. Patterson Place

23C. DATE SIGNED

7/28/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 30 1953.

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

Belair Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Schimunek Funeral Home

ADDRESS

2601-03-05 E. Madison Street.

CERTIFICATE OF DEATH

|                                 |  |                                       |  |                                       |  |   |  |                                   |  |
|---------------------------------|--|---------------------------------------|--|---------------------------------------|--|---|--|-----------------------------------|--|
| 1. Name of deceased             |  | 2. Sex                                |  | 3. Race                               |  | 4. Date of birth                        |  | 5. Date of death                  |  |
| 6. Place of birth               |  | 7. Usual residence                    |  | 8. Cause of death                     |  | 9. Manner of death                      |  | 10. Signature of physician        |  |
| 11. Signature of registrar      |  | 12. Signature of informant            |  | 13. Signature of medical examiner     |  | 14. Signature of coroner                |  | 15. Signature of funeral director |  |
| 16. Signature of health officer |  | 17. Signature of local health officer |  | 18. Signature of state health officer |  | 19. Signature of federal health officer |  | 20. Signature of other official   |  |

5-540  
53 6902BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6902  
Registered No.

TH NO.

NAME OF DECEASED  
(Last name or Print)

MICHAEL SMALLEY

2. DATE  
OF  
DEATH

7/27/53

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

SINAI HOSPITAL, INC. OF BALTIMORE

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

MALE WHITE

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

DIVORCED

USUAL OCCUPATION (Give kind of  
occupation during most of working life, even if retired)

BUTCHER

10B. KIND OF BUSINESS OR  
INDUSTRYGreat ATLANTIC  
TEA CO.

FATHER'S NAME

JOHN SMALLEY

WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

UNKNOWN

16. SOCIAL  
SECURITY NO.

161-18-1214

17. INFORMANT

ADDRESS

PATIENT

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) SEPTICEMIA

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) PNEUMONIA

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

HEPATIC CIRRHOSIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26 1953, to 7/27, 1953, that I last saw the  
deceased alive on 7/27, 1953, and that death occurred at 3:05 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Stanley B. Gould M. D.

Sinai Hospital of Balto.

7/28/53

A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BONIAL

JULY 31-1953

ST. JOSEPH CEM.

HAZELTON

PA

TE RECEIVED BY  
CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

29 1953

Huntington Williams, M.D.

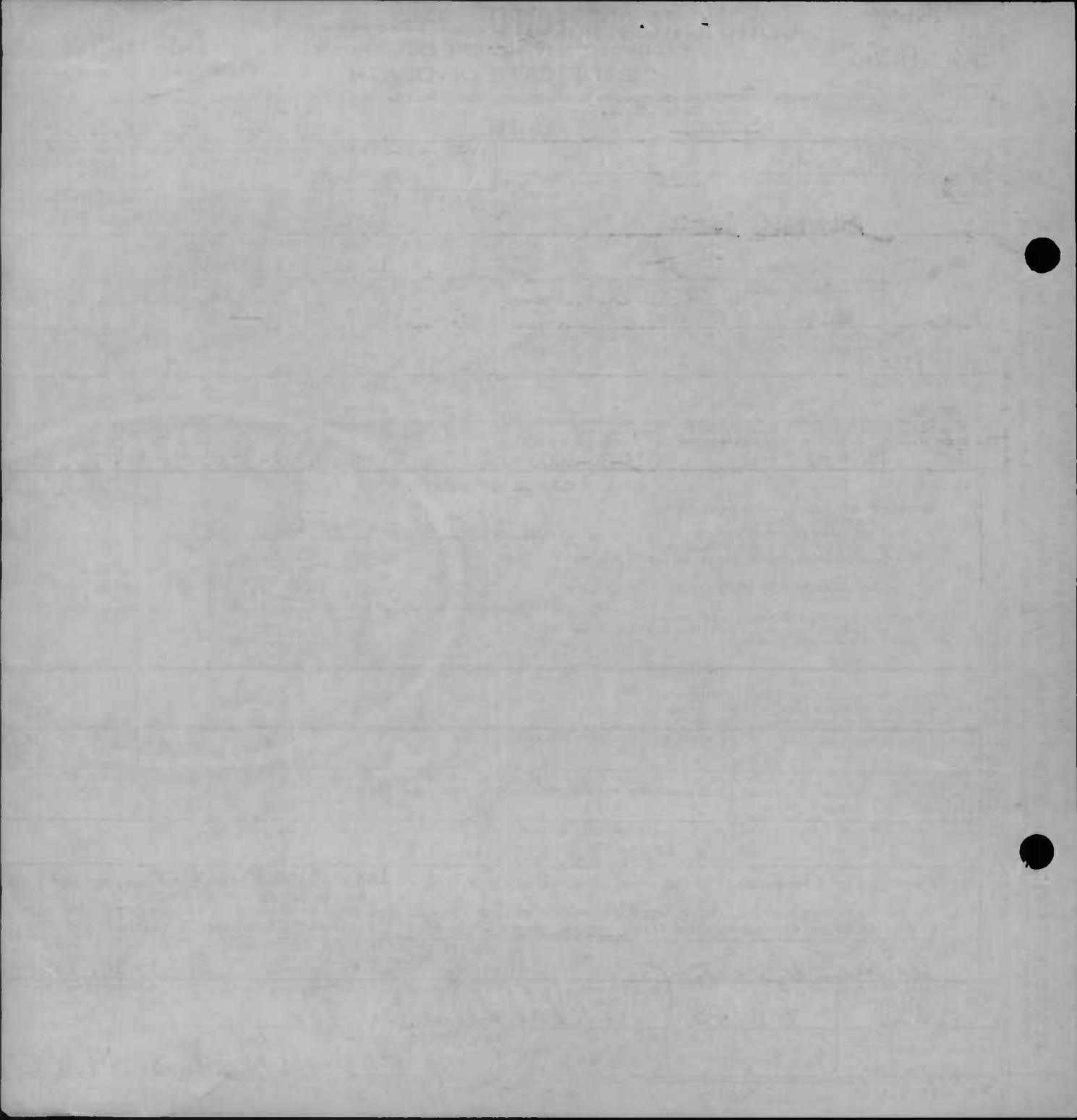
Frank Della Noce 322 S. HIGH ST

VS 150

6446A









MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

W-416  
53 6904

X 53 6904

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OWEN WOLFORD

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

Pa.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

US Public Health Service Hospital

Wyman Pk. Drive & 1st Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Boyer

D. STREET ADDRESS (If rural, give location)

5. LENGTH OF STAY IN BALTIMORE

19 days

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

6/28/02

9. AGE (In years last birthday)

51

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

oilier

10B. KIND OF BUSINESS OR INDUSTRY

seafarer

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Wolford

14. MOTHER'S MAIDEN NAME

Nannie Wolford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
362-20-3205

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

150X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration pneumonia, secondary to

Recent

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tracheoesophageal fistula, secondary to carcinoma of esophagus

Approx. 8 mos.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1953, to July 29, 1953, that I last saw the deceased alive on July 29, 1953, and that death occurred at 3:55A m., from the causes and on the date stated above.

23A. SIGNATURE

J.A. Hunter, Clinical Director

23B. ADDRESS

US PHS Hospital, Balto, Md.

23C. DATE SIGNED

7/29/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

removal

24B. DATE

7/29/53

24C. NAME OF CEMETERY OR CREMATORY

West Sunbury

24D. LOCATION (City, town, or county) (State)

West Sunbury, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D., 24m. Cook, Jr.,

25. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul Street

VS 150

66255

US Public Health Service

Dr. J. L. Davis & Son

1917

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W-231  
53 6905BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6905  
Registered No.

TH NO.

|  |                    |  |  |
|--|--------------------|--|--|
| NAME OF DECEASED (MRS. L. JUDSON) WEST FALL  |                    | 2. DATE OF DEATH 7/29/53   |  |
| PLACE OF DEATH: Baltimore City, Maryland   |                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY - |  |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR TITUTION UNION MEMORIAL HOSP  |                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE - 12 27-48                   |  |
| Length of stay in Baltimore ? Yrs. Mos. Days   |                    | D. STREET ADDRESS (If rural, give location)<br>513 HOLLEN ROAD   |  |
| 5. SEX F   | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W  | 8. DATE OF BIRTH 7/8/1876                            |
| 9. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)<br>NONE - HOUSEWIFE  |                    | 10. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) 77                   |
| FATHER'S NAME JOSHIAH M. LEWIS   |                    | 11. BIRTHPLACE (State or foreign country) NEW YORK   |  |
| WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br>UNKNOWN -  |                    | 12. CITIZEN OF WHAT COUNTRY? U.S.  | 14. MOTHER'S MAIDEN NAME AUGUSTA JUDKINS             |
| 16. SOCIAL SECURITY NO. ?  |                    | 17. INFORMANT ADDRESS MR. VANDER VOORT WILLIAMS - SAME   |  |
| 8. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>A. <del>Coronary</del> Myocardial infarction<br>B. Coronary thrombosis<br>C. Anteriosclerotic heart disease<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Hypertension |                    |  | INTERVAL BETWEEN ONSET AND DEATH<br>0<br>0<br>?<br>? |
| 9A. DATE OF OPERATION 0  |                    | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                    | 21D. HOW DID INJURY OCCUR?   |  |
| 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 7/28, 1953, to 7/29, 1953, that I last saw the deceased alive on 7/29, 1953, and that death occurred at 7:15 A.M., from the causes and on the date stated above.  |                    |  |  |
| 23A. SIGNATURE Henry S. Knock, Jr.   |                    | 23B. ADDRESS Union Memorial Hosp.  |  |
| 23C. DATE SIGNED 7/29/53   |                    | 23D. DATE SIGNED   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                    | 24B. DATE 8/1/53   |  |
| 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery   |                    | 24D. LOCATION (City, town, or county) (State) Woodlawn Maryland  |  |
| 25. FUNERAL DIRECTOR   |                    | ADDRESS  |  |
| 25. FUNERAL DIRECTOR   |                    | ADDRESS  |  |



| 53 6906   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 53 6906  |  |
|---|--|--|--|--|--|
| 53 6906   |  | 53 6906  |  | 53 6906  |  |
| NAME OF DECEASED (Type or Print)  |  | Infant of Elizabeth Taylor (155440)  |  | 2. DATE OF DEATH April 5, 1953   |  |
| PLACE OF DEATH: Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  | A. STATE Maryland B. COUNTY BALTO.                                       |  |
| FULL NAME OF (If not in hospital or institution, give street address or location)   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                           |  | Lutherville 53-00  |  |
| The Johns Hopkins Hospital  |  | D. STREET ADDRESS (If rural, give location)  |  | Bellona Avenue   |  |
| Length of stay in Baltimore   |  | Infant   |  | Yrs. Mos. Days   |  |
| SEX Male  |  | 6. COLOR OR RACE Negro   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                          |  |
| A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)  |  | 10a. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH April 5, 1953   |  |
| FATHER'S NAME Arthur Taylor   |  | 14. MOTHER'S MAIDEN NAME Elizabeth Davis   |  | 9. AGE (In years last birthday) 8 5                                      |  |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 11. BIRTHPLACE (State or foreign country) Maryland                       |  |
| 17. INFORMANT Hospital Records  |  | ADDRESS  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 18. 761.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                               |  | CAUSE OF DEATH Anoxia  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES   |  | DUE TO   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | DUE TO   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | DUE TO   |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from April 5th, 1953 to April 5th, 1953, that I last saw the deceased alive on April 5th, 1953, and that death occurred at 1.30 P.m., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE  |  | 23B. ADDRESS The Johns Hopkins Hospital  |  | 23C. DATE SIGNED 7/16/53   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| 24D. LOCATION (City, town, or county) (State)   |  | 24E. FUNERAL DIRECTOR  |  | 24F. ADDRESS   |  |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR   |  | 24H. REGISTRAR'S SIGNATURE   |  | 24I. ADDRESS   |  |
| JUL 29 1953   |  | Huntington Williams, M.D.  |  | 24J. ADDRESS   |  |

1900

THE UNIVERSITY OF CHICAGO

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|  |  |  |   |
|--|--|--|---|
| <b>CERTIFICATE AMENDED</b> 10/19/53 ES<br><b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>X 53 6907</b><br>Registered No.   |   |
| PART NO.   |  |  |   |
| NAME OF DECEASED<br>(Type or Print) <b>PHIPPS, BLAINE</b>  |  | 2. DATE OF DEATH <b>July 29, 1953</b>  |   |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>DE LAIR</b> |   |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>FRANKLIN SQUARE HOSPITAL</b>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |   |
| Length of stay in Baltimore <b>?</b> Yrs. Mos. Days  |  | D. STREET ADDRESS (If rural, give location) <b>MC PHAIL ROAD 62-00</b>   |   |
| SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>   | 8. DATE OF BIRTH <b>Nov 19th, 1908</b>                            |
| 9. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) <b>SURFACE COMBUSTION</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>45</b>                         |
| FATHER'S NAME <b>?</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                        |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  | 14. MOTHER'S MAIDEN NAME <b>?</b>                                 |
| 17. INFORMANT  |  | ADDRESS  |   |
| 18. <b>193x</b> I <b>I</b> <b>CAUSE OF DEATH</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  | INTERVAL BETWEEN ONSET AND DEATH                                  |
| (A) <b>INTRACRANIAL TUMOR</b><br>DUE TO <b>(Ependymoma- Colloid cystic type.)</b>  |  |  |   |
| (B) <b>INTRACRANIAL TUMOR</b><br>DUE TO  |  |  |   |
| (C)  |  |  |   |
| 19A. DATE OF OPERATION <b>7/29</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7/28/53</b> , 1953, to <b>7/29</b> , 1953, that I last saw the deceased alive on <b>7/29</b> , 1953, and that death occurred at <b>1:30 Am.</b> , from the causes and on the date stated above.  |  |  |   |
| 23A. SIGNATURE <b>C. Fernando</b>  |  | 23B. ADDRESS <b>Franklin Square Hosp.</b>  | 23C. DATE SIGNED <b>7/29/53</b>                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  | 24B. DATE <b>Aug. 1, 1953</b>  | 24C. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>   | 24D. LOCATION (City, town, or county) (State) <b>Bel Air, Md.</b> |
| 25. FUNERAL DIRECTOR, ADDRESS  | REGISTRAR'S SIGNATURE <b>Huntington Williams</b>   |  |   |
| VS 190 <b>1953</b>   |  |  |   |

See query reply in Document file.

W-53-6  
53 6908  
NJ 171939

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6908

BIRTH NO. 53-15302

1. NAME OF DECEASED  
(Type or Print) **Baby Girl - Beatrice Winder**

2. DATE OF DEATH **7-6-1953**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION **Baltimore City Hospitals**  
**4940 Eastern Avenue**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

C. Length of stay in Baltimore **life**  
Yrs. Mos. Days

O. STREET ADDRESS (If rural, give location)  
**2609 Pierpont St. #30**

5. SEX  
**Female**

6. COLOR OR RACE  
**Negro**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Single**

8. DATE OF BIRTH  
**7-6-1953**

9. AGE (in years last birthday) **3**  
If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
**Monroe Winder**

14. MOTHER'S MAIDEN NAME  
**Beatrice Richardson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**B.C.H. 4940 Eastern Ave. (records)**

18. **776x I** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Prematurity**  
DUE TO  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO  
**1-5**  
DUE TO  
(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  
20. AUTOPSY? YES ☒ NO ☐  
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21F. HOW DID INJURY OCCUR?

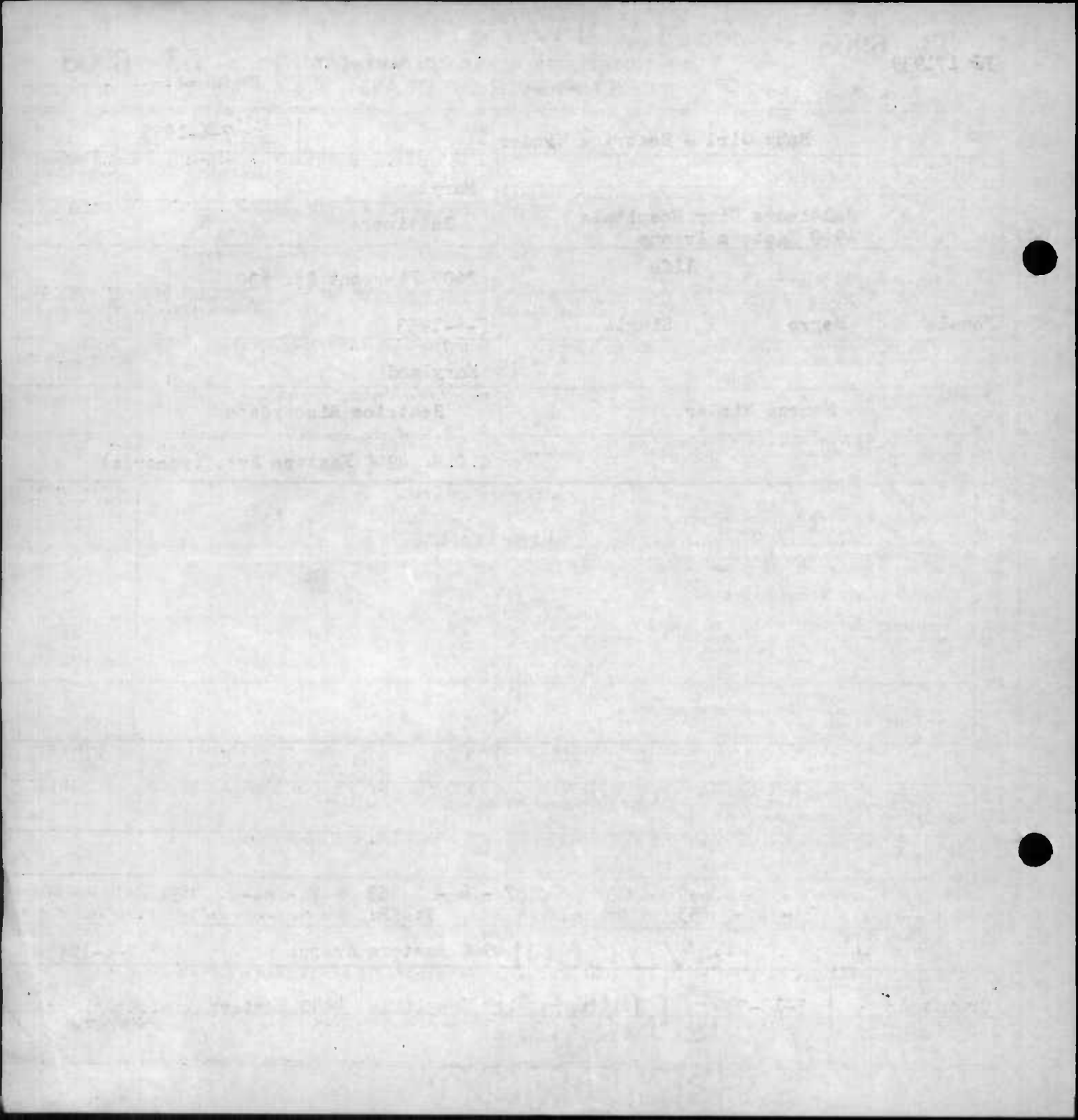
22. I hereby certify that I attended the deceased from **7-6-**, 1953, to **7-6-**, 1953, that I last saw the deceased alive on **7-6-**, 1953, and that death occurred at **7:45 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE **H. J. Williams, M.D.** 23B. ADDRESS **4940 Eastern Avenue** 23C. DATE SIGNED **7-6-1953**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Cremated** 24B. DATE **7-13-53** 24C. NAME OF CEMETERY OR CREMATORY **Baltimore City Hospitals** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **29-7-53** REGISTRAR'S SIGNATURE **Huntington Williams, M.D.** 25. FUNERAL DIRECTOR ADDRESS

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly written. Physicians: please write the causes of death clearly and legibly.

53 6909

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

53 6909

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ACY P. YOUNG

2. DATE  
OF  
DEATH

JULY 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

VA HOSPITAL

BALTIMORE 18, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

TALBOTT

C. CITY OR TOWN

EASTON

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

RT. 4, BOX 84

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

FEB. 17, 1911

9. AGE (In years  
last birthday)

42

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR  
INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MORDECAI YOUNG

14. MOTHER'S MAIDEN NAME

MARTHA WALLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

9/22/42 - 12/14/44

16. SOCIAL  
SECURITY NO.

138-01-7611

17. INFORMANT

ADDRESS

VA HOSPITAL RECORDS VAH, BALTO 18, MD.

18.

002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) FIBROCASEOUS TUBERCULOSIS, BILATERAL

UNKNOWN

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) PULMONARY EDEMA

2 HOURS

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

UREMIA

10 DAYS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

VA m.

21e. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 14, 1953, to JULY 28, 1953 and that death occurred at 8:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE

DONALD R. SCHULTZ

23b. ADDRESS

VAH BALTIMORE 18, MARYLAND

23c. DATE SIGNED

7/28/53

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 29 1953

Huntington Williams, M.D. E. R. Baw 802 Madison Ave.

VS 150

82010





MARGIN RESERVED FOR BINDING

PLEASE WRITE PEN ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-436  
53 6910

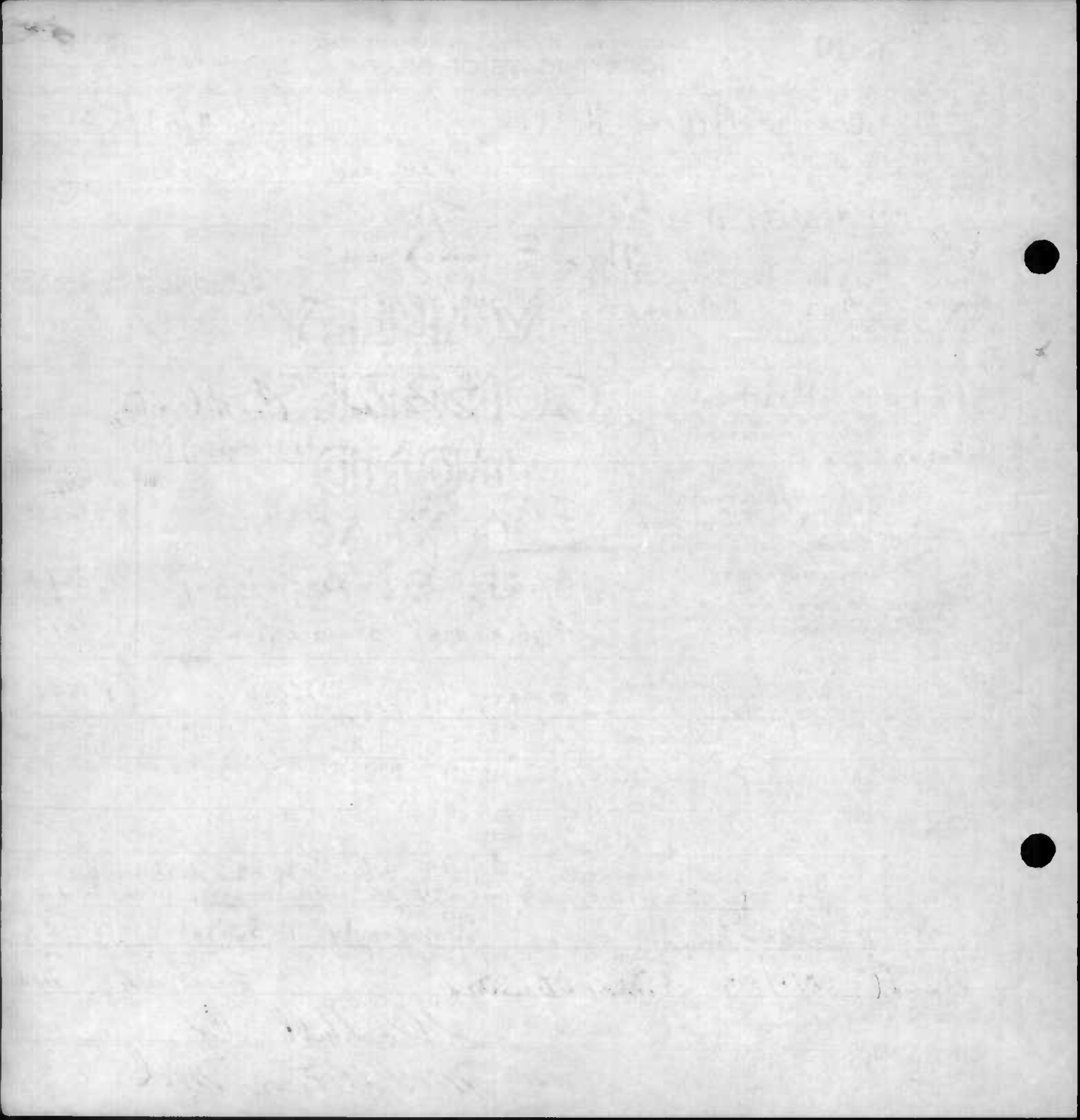
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6910

BIRTH NO.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>George Millard Holter</b>  |                                  | 2. DATE OF DEATH<br><b>7/29/53</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Carroll</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Sykesville</b>  |  |
| C. Length of stay in Baltimore<br><b>2 hrs.</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>Route 2</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | B. DATE OF BIRTH<br><b>12/25/81</b>          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>71</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Peter Holter</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Michaela Proffert</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Unknown</b>  | 16. SOCIAL SECURITY NO.          | 17. INFORMANT<br><b>Virginia Carneal (daughter)</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>420.1</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4-6 hrs.</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  | DUE TO<br>(A) <b>Intractable Shock</b><br>(B) <b>Myocardial Insufficiency</b><br>(C) <b>Myocardial Infarction</b>                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  | 2. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 19A. DATE OF OPERATION   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                     |  |
| 22. I hereby certify that I attended the deceased from <b>July 29, 1953</b> to <b>July 29, 1953</b> , that I last saw the deceased alive on <b>July 29, 1953</b> , and that death occurred at <b>2:15 p.m.</b> , from the causes and on the date stated above. |                                  | 23A. SIGNATURE<br><b>Wm. H. Slasman, Jr.</b>   |  |
| 23B. ADDRESS<br><b>University Hospital</b>   |                                  | 23C. DATE SIGNED<br><b>7/29/53</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>8/1/53</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Middletown Md</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Frederick Co. Md</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                                  | 25. FUNERAL DIRECTOR<br><b>Shadwell Co.</b>  |  |
| REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>  |                                  | ADDRESS<br><b>Middletown Md</b>  |  |

JUL 29 1953



65-2

6911

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6911

Registered No. \_\_\_\_\_

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Name or Print)<br><b>Henri P. des Garennes</b>   |                              | 2. DATE OF DEATH<br><b>July 29-53</b>   |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b> B. COUNTY _____ |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Jenkins Memorial Hospital</b>  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 15-12</b>                      |   |
| 6. LENGTH of stay in Baltimore<br>Yrs. _____ Mos. _____ Days _____   |                              | D. STREET ADDRESS (If rural, give location)<br><b>3403 Park Heights Ave</b>   |   |
| 7. SEX<br><b>W</b>   | 8. COLOR OR RACE<br><b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>W</b>   | 10. DATE OF BIRTH<br><b>Feb. 21, 1875</b> |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Post Master</b>  |                              | 12. AGE (In years last birthday)<br><b>78 yrs.</b>  |   |
| 13. FATHER'S NAME<br><b>T. Jean Des Garennes</b>   |                              | 14. BIRTHPLACE (State or foreign country)<br><b>France</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. MOTHER'S MAIDEN NAME<br><b>Eugenie Rene</b>  |                              | 18. INFORMANT<br><b>Raymond Records</b>   |   |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Anteroseptal Cardiovascular Disease &amp; failure &amp; uremia</b> |                              | 20. INTERVAL BETWEEN ONSET AND DEATH  |   |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Bronchial Asthma</b>  |                              | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.         |   |
| 23. DATE OF OPERATION<br><b>July 31-53</b>   |                              | 24. MAJOR FINDINGS OF OPERATION   |   |
| 25. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 26. DATE OF OPERATION   |   |
| 27. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                              | 28. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                    |   |
| 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                              | 30. TIME (Month) (Day) (Year) (Hour) OF INJURY  |   |
| 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 32. HOW DID INJURY OCCUR?   |   |
| 33. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:40 P. M.</b> from the causes and on the date stated above.                                    |                              |   |   |
| 34. SIGNATURE<br><b>James E. Rowe Jr.</b>  |                              | 35. ADDRESS<br><b>Jenkins</b>   |   |
| 36. DATE<br><b>July 31-53</b>  |                              | 37. NAME OF CEMETERY OR CREMATORY<br><b>St Johns Cemetery</b>   |   |
| 38. LOCATION (City, town, or county)<br><b>H Westminster Md</b>  |                              | 39. DATE SIGNED<br><b>7/29/53</b>   |   |
| 40. RECEIVED BY<br><b>Huntington Williams</b>  |                              | 41. REGISTRAR'S SIGNATURE<br><b>B. Bankard</b>  |   |
| 42. FUNERAL DIRECTOR<br><b>H Westminster Md</b>  |                              | 43. ADDRESS   |   |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

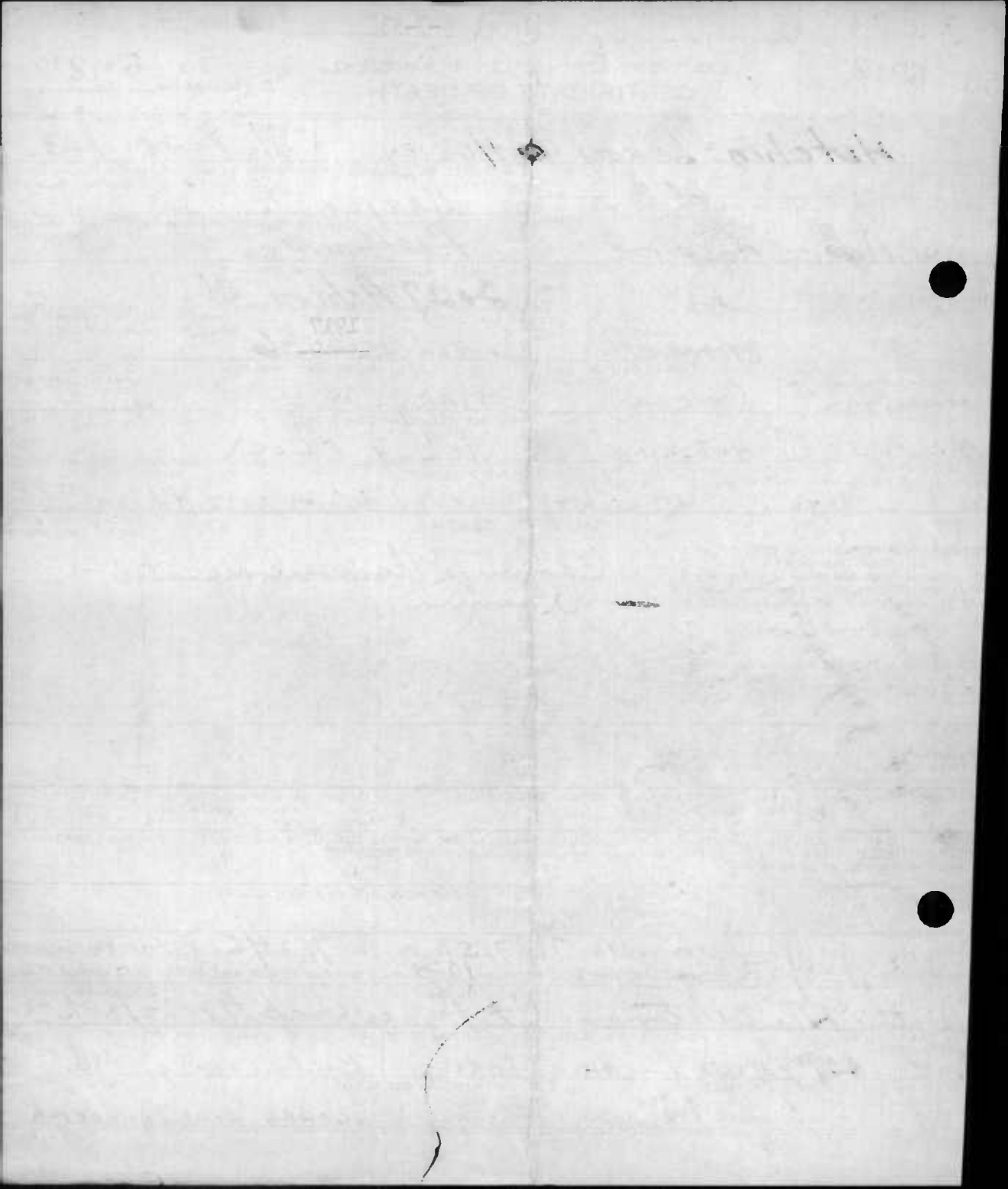
July 1914

DEATH OF

John J. ...

...

| 7-325  |  | CERTIFICATE CORRECTED 8-3-53  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 53 6912  |  |
|--|--|---|--|--|--|--|--|
| 53 6912  |  | CERTIFICATE OF DEATH  |  | Registered No. 53 6912   |  |  |  |
| NAME OF DECEASED (Print)<br><b>Hutchins Leroy HARVEY</b>   |  | 2. DATE OF DEATH<br><b>7-28-1953</b>  |  |  |  |  |  |
| PLACE OF DEATH:<br>Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY |  |  |  |  |  |
| 5. NAME OF (If not in hospital or institution, give street address or location)<br><b>St. Agnes Hospital</b>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 20-03</b>                      |  |  |  |  |  |
| 6. COLOR OR RACE<br><b>W</b>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>   |  | 8. DATE OF BIRTH<br><b>January 17, 1907</b>                              |  | 9. AGE (In years last birthday)<br><b>46</b>                               |  |
| 10. KIND OF BUSINESS OR INDUSTRY<br><b>GROCERY</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |  |  |
| 13. DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>None</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-05-6091</b>   |  | 17. INFORMANT<br><b>Edna M. Hutchins</b>                                 |  | ADDRESS<br><b>2027 Ashton St.</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>HELEN FLECK</b>   |  |   |  |  |  |  |  |
| 15. CAUSE OF DEATH<br><b>Chronic Glomerulonephritis - Uremia</b>   |  |   |  |  |  |  |  |
| 18. ANTECEDENT CAUSES<br>DISEASE OR CONDICTION DIRECTLY LEADING TO DEATH<br>This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.  |  |   |  |  |  |  |  |
| 19. SEASONS OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |  |  |  |  |  |
| 20. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                   |  | 21C. WHERE OIO (If in Baltimore City, give exact location) INJURY OCCUR? |  |  |  |
| 21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21E. HOW DID INJURY OCCUR?  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>7/27/53</b> , 19 <b>53</b> , to <b>7/28/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/28/53</b> , and that death occurred at <b>10:45</b> m., from the causes and on the date stated above. |  | 23. ADDRESS<br><b>St. Agnes Hospital</b>  |  | 23C. DATE SIGNED<br><b>7/28/53</b>                                       |  |  |  |
| 24A. NAME OF REGISTER<br><b>Huntington</b>   |  | 24B. DATE<br><b>July 31, 1953</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>               |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. County, Md.</b> |  |
| 25. FUNERAL DIRECTOR<br><b>George L. Schwab</b>  |  | 25. ADDRESS<br><b>2101 Frederick Ave.</b>   |  |  |  |  |  |
| 97053  |  |   |  |  |  |  |  |





W-656  
53 6913BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6913  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Florence Irene Warner

2. DATE  
OF  
DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2520 W. Fayette St.

C. Length of stay in Baltimore

49- Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-02

D. STREET ADDRESS (If rural, give location)

2520 W. Fayette St.,

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 26, 1904

9. AGE (In years last birthday)

49

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sales

10B. KIND OF BUSINESS OR INDUSTRY

Stationery

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William E. Warner

14. MOTHER'S MAIDEN NAME

Eva S. Orrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Eva S. Warner 2520 W. Fayette St.

18. 241X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cor Pulmonale

1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Chronic Bronchitis &amp; Emphysema 10 yrs.

DUE TO

(C) Pneumotorax &amp; Cardiac Failure 3 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-25, 1953, to 7-28, 1953, that I last saw the deceased alive on 7-28, 1953, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

4A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7-31-1953

Loudon Park

Baltimore,

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 29 1953

Huntington

G. Howard Strong 3207 W. North Ave.,

VS 150

49063

Dr. John P. Urlock  
1227 Wash Blvd.

B-146  
53 6914BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6914  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ORVILLE E. BABLER

2. DATE

OF  
DEATH

JULY 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

VA HOSPITAL

BALTIMORE 18, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

58 W. BIDDLE STREET

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

AUG. 15, 1908

9. AGE (In years,  
last birthday)

45 1/4

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

ELECTRIC PLATER

10B. KIND OF BUSINESS OR  
INDUSTRY

ELECTRO-PLATING

11. BIRTHPLACE (State or foreign country)

WISCONSIN

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EZRA BABLER

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

YES

11/6/25 - 10/31/47

16. SOCIAL  
SECURITY NO.

216-28-0684

17. INFORMANT

ADDRESS

VA HOSPITAL RECORDS VAH, BALTO 18 MD.

18. 002X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)CAUSE OF DEATH  
TUBERCULOSIS, PULMONARY, BILATERAL  
WITH CAVITATIONINTERVAL BETWEEN  
ONSET AND DEATH

UNKNOWN

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

VA

m.

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 17, 1953, to JULY 28, 1953, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE

JOHN T. KALISH

23B. ADDRESS

VAH BALTIMORE 18, MARYLAND

23C. DATE SIGNED

7/28/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-30-53

24C. NAME OF CEMETERY OR CREMATORY

Baeto. Natl.

24D. LOCATION (City, town, or county) (State)

Baeto

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

ADDRESS

Melchior J. Blight 6019 Harp



2-500

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6915

BIRTH NO. 6915

1. NAME OF DECEASED  
(Type or Print)

Sara Leon

2. DATE  
OF  
DEATH

7/28/53

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Sinai Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

MD

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 13-01

d. STREET ADDRESS (If rural, give location)

2458 Callow Ave

c. Length of stay in Baltimore

60

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

8/15/87

9. AGE (in years last birthday)

65

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Beautician

10b. KIND OF BUSINESS OR INDUSTRY

Own Shop

13. FATHER'S NAME

Jacob Leon

11. BIRTHPLACE (State or foreign country)

New York, NY.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Nettie Radofsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Harry Burtrick - 2810 Suffolk Ave.

18. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Myocardial Infarction

(B)

DUE TO

Coronary Thrombosis

(C)

Arteriosclerosis Heart Dis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

shock

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ m. NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26, 1953 to 7/28, 1953 that I last saw the deceased alive on 7/28, 1953, and that death occurred at 3:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE

W. J. Miller

M. D.

23b. ADDRESS

Sinai Hospital

23c. DATE SIGNED

7/28/53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

7/30/53

24c. NAME OF CEMETERY OR CREMATORY

Baltimore Hebrew

24d. LOCATION (City, town or country)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

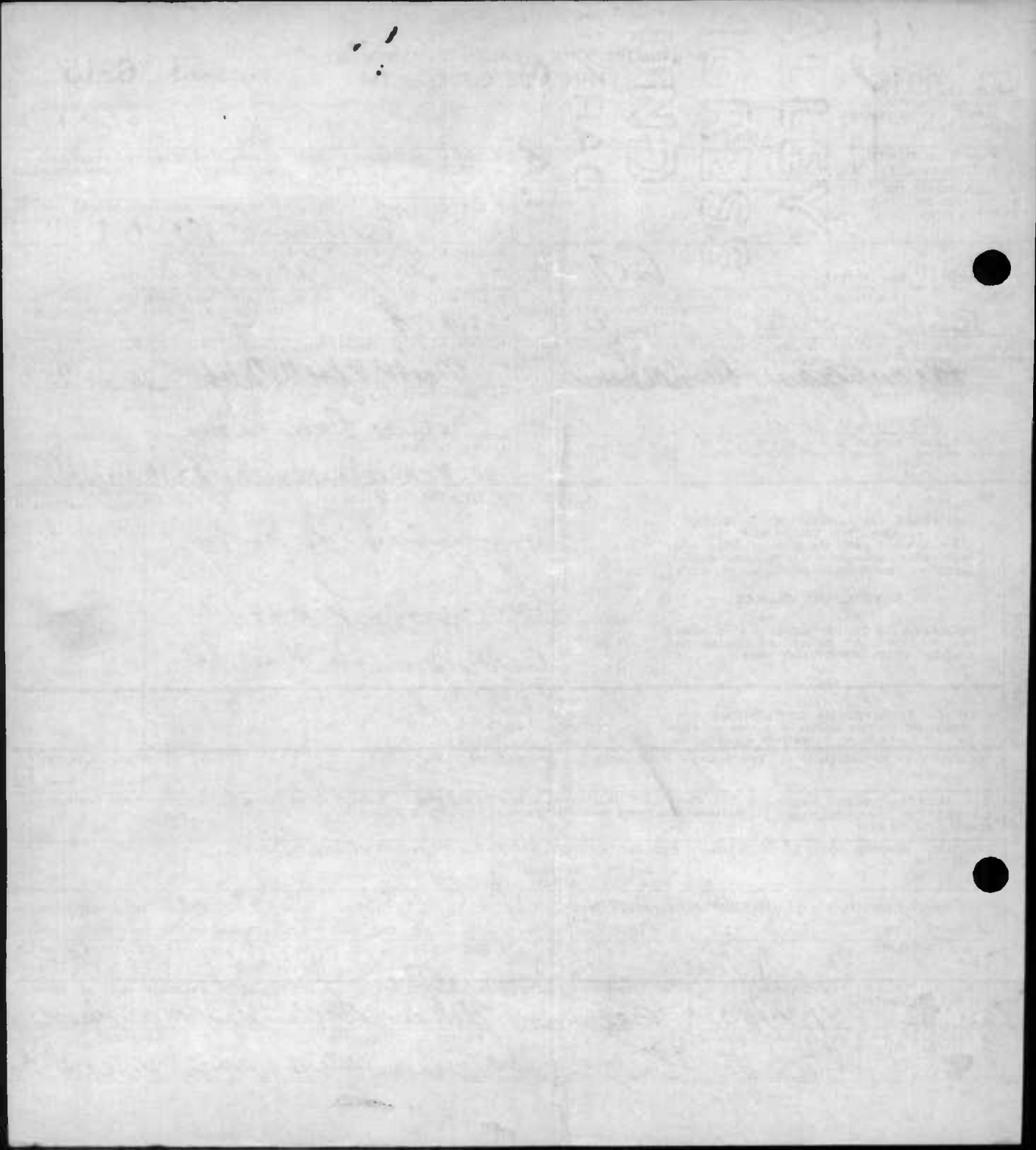
ADDRESS

Bro. 1124-26 W. North Ave

VS 150

74085

MEDICAL CERTIFICATION





5-320

03 6916

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6916

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

HARRIS

GOETZ (GETZ)

2. DATE  
OF  
DEATH

7-29-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Leondale

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md

15-13

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
4319 Reisterstown Rd

5. Length of stay in Baltimore

70

Yrs.  
Mos.  
Days

6. COLOR OR RACE

male white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year If Under 24 Hours  
88 Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tactor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Russia12. CITIZEN OF WHAT COUNTRY?  
U.S.G.

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
Yes, no or unknown

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mrs. Berj. Sonneborn-dane

18. 493X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-27, 1953, to 7-29, 1953, that I last saw the deceased alive on 7-29, 1953, and that death occurred at 10:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

M. D.

23B. ADDRESS

Leondale Home

23C. DATE SIGNED

7-29-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-30-53

24C. NAME OF CEMETERY OR CREMATORY

Dover Israel

24D. LOCATION (City, town or county) (State)

Balto, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Cutaw Pl

VS 150

WALLEY  
CONGRESS  
JOURNAL  
JANUARY  
1875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 53 6917

53 6917

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES HERBERT DAWSON

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

West Virginia

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or location)

Children's Hospital School

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Gerrardstown

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 4, 1945

9. AGE (In years last birthday)

8

If Under 1 Year Months: Days

— 25

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Berkeley Co. W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

John Dawson

14. MOTHER'S MAIDEN NAME

Elsie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

John Dawson, Gerrardstown, W.Va.

18. 730.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Pulmonary fat embolism due to osteotomy of the right femur due to congenital deformities of pelvis and legs.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 29, 1953

19B. MAJOR FINDINGS OF OPERATION

Osteotomy of right femur

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Children's Hospital School Greenspring Avenue near Keyworth Ave.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 29, 1953 Noon m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Syncope during complicating surgery on

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

23B. CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

23C. DATE SIGNED

July 29, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-1-1953

24C. NAME OF CEMETERY OR CREMATORY

Mt Olive

24D. LOCATION (City, town, or county) (State)

Gerrardstown

W. Va

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HOWARD K. BROWN

ADDRESS

MARTINSBURG W. Va

See letter in Document File from Dr. Russell S. Fisher, Chief Medical Examiner  
of Baltimore, Md. relating true cause of death from microscopic examination.

5-520

53 6918

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6918  
Registered No.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN SCHWING</b>   |                                  |   | 2. DATE OF DEATH <b>JULY 27-1953</b>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>BALTIMORE CITY</b> |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>2533 W. Lombard Street</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE CITY</b>  |   |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  |   | O. STREET ADDRESS (If rural, give location)<br><b>2533 W. LOMBARD STREET</b>   |   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>9-1-1872</b>  | 9. AGE (In years last birthday)<br><b>80</b>  | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b>  |   |   |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |
| 13. FATHER'S NAME<br><b>HENRY SCHWING</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Rosenschwigg</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO.</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   |   |
| 17. INFORMANT ADDRESS<br><b>MARGARET SCHWING... SAME</b>   |                                  |   |  |   |   |
| 18. <b>332X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Branch pneumonia, bilateral</b><br>DUE TO<br><b>Cerebral thrombosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>1 1/2 years</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |   |   |
| II<br>OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>Feb. 21, 1952</b> to <b>July 27, 1953</b> that I last saw the deceased alive on <b>July 27, 1953</b> , and that death occurred at <b>6:05 P.M.</b> from the causes and on the date stated above.   |                                  |   |  |   |   |
| 23A. SIGNATURE<br><b>Albert E. Ruden</b>   |                                  | 23B. ADDRESS<br><b>2517 W. Baltimore Street</b>   |  | 23C. DATE SIGNED<br><b>7/29/53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 24B. DATE<br><b>JULY 30-53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>                   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MARYLAND</b>   |                                  | 25. FUNERAL DIRECTOR<br><b>Huntington Williams, M.D. &amp; P. Whippert &amp; Son</b>                      |  | 25. ADDRESS   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 30 1953</b>   |                                  | VS 150  |  |   |   |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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53 6919

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6919  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Addie B. Gutman

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)Marlborough Apt-7-F  
Wilson & Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Md. 14-01

D. STREET ADDRESS (If rural, give location)

Wilson St. &amp; Eutaw Place

E. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

8-10-1870

9. AGE (In years  
last birthday)

82

10. Under 1 Year  
Months: Days

11 12

11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abraham Brafman

14. MOTHER'S MAIDEN NAME

Weiglien

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Victor F. Burger, Marlborough Apt.

18. 153 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Splenic Flexure  
with metastases in liver  
metastatic involvementabout  
2 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive Cardis Vas.  
Disease.about  
10 years

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, place bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from May 31, 1928, to 7/29/1953 that I last saw the deceased alive on 7/28/1953, and that death occurred at 2:20 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Theodore H. Morrison

M. D.

11 E. Chase St

7/30/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7-30-53

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Hebrew Cem.

24D. LOCATION (Cty, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 30 1953

Huntington Williams, M.D.

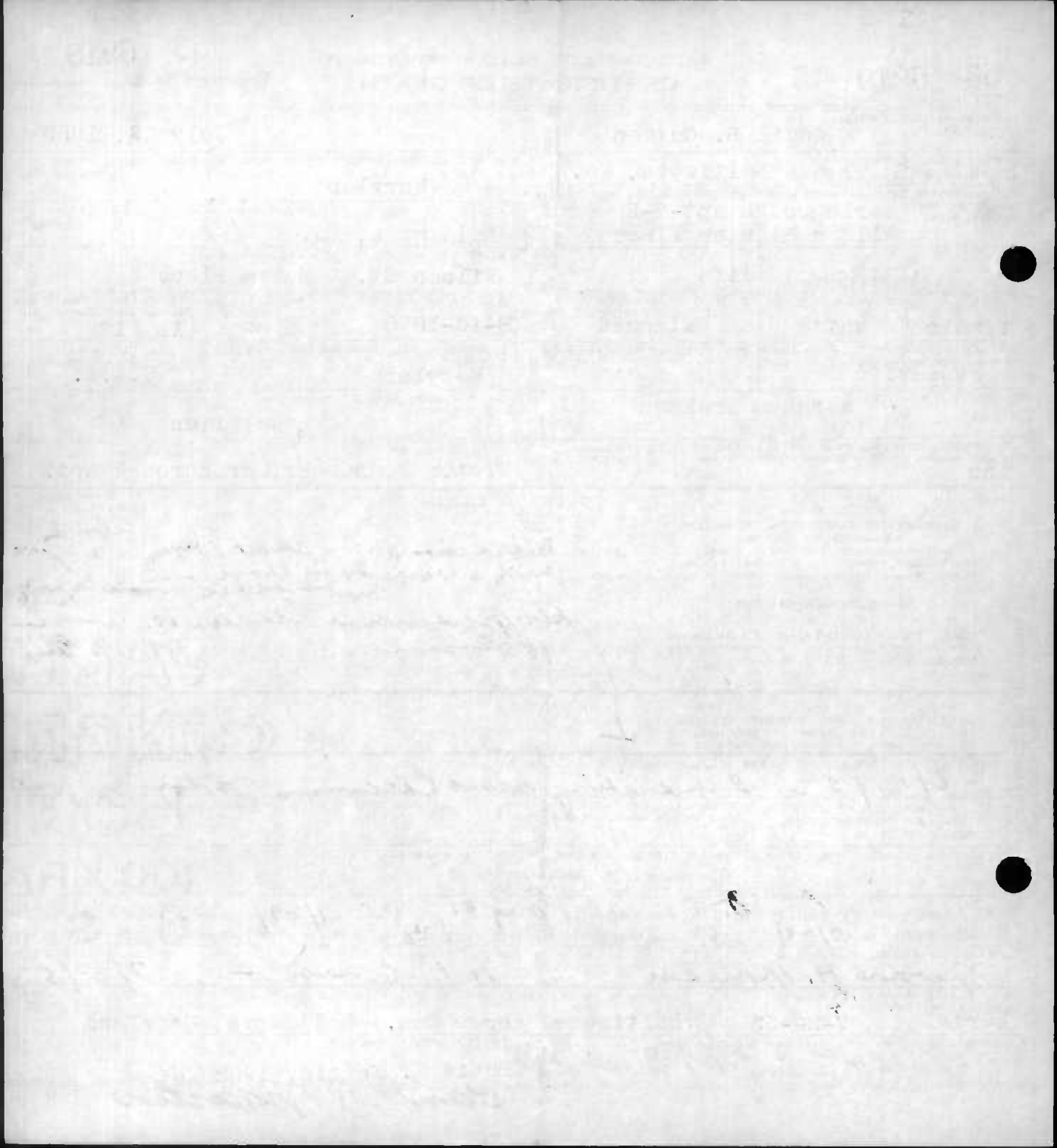
David R. Martin, 1902 Eutaw Place

David R. Martin

VS 150

MEDICAL CERTIFICATION

correct age is especially important. Physicians, please enter the causes of death clearly and legibly.



## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 6920

BIRTH NO. 53 6920

50-22121

1. NAME OF DECEASED  
(Type or Print)

JUDY ROLLINS

2. DATE  
OF  
DEATH

July 27, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (not in hospital or institution, give street address or location)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1304 N. Broadway

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE/MARRIED.

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10-11-50

9. AGE (In years

last birthday)

3

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Roy Rollins

14. MOTHER'S MAIDEN NAME

Palestine Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Roy Rollins 1304 N. Broadway

18.

571-1  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Dehydration

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diarrhea

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph A. Jachimec

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
July 28, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

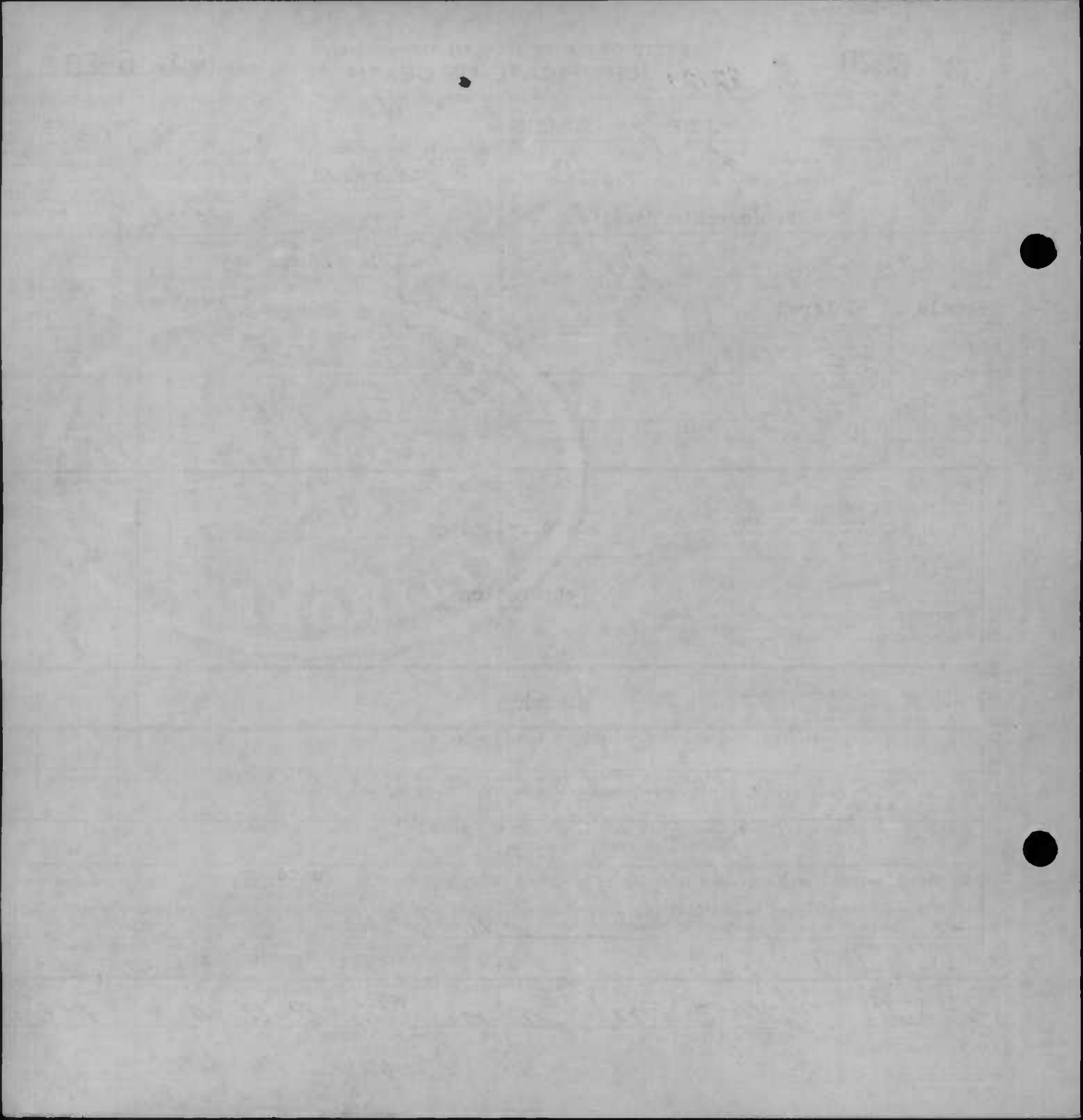
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

N-140

53 6921

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6921  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OTIS NOBLE

2. DATE  
OF  
DEATH

7-27-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

D. STREET ADDRESS (If rural, give location)  
950 W. Saratoga

c. Length of stay in Baltimore 48

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Sept. 2, 1904

9. AGE (In years  
last birthday)

48

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Aaron Noble

14. MOTHER'S MAIDEN NAME

Marion ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 581.0 and 156.1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Internal hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Ruptured Oesophageal Varices

(C)

Portal cirrhosis  
Possible Carcinoma of Liver

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ ND ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 7-13, 1953, to 7-27, 1953, that I last saw the  
deceased alive on 7-27, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

George R. Leno

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

7-28-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

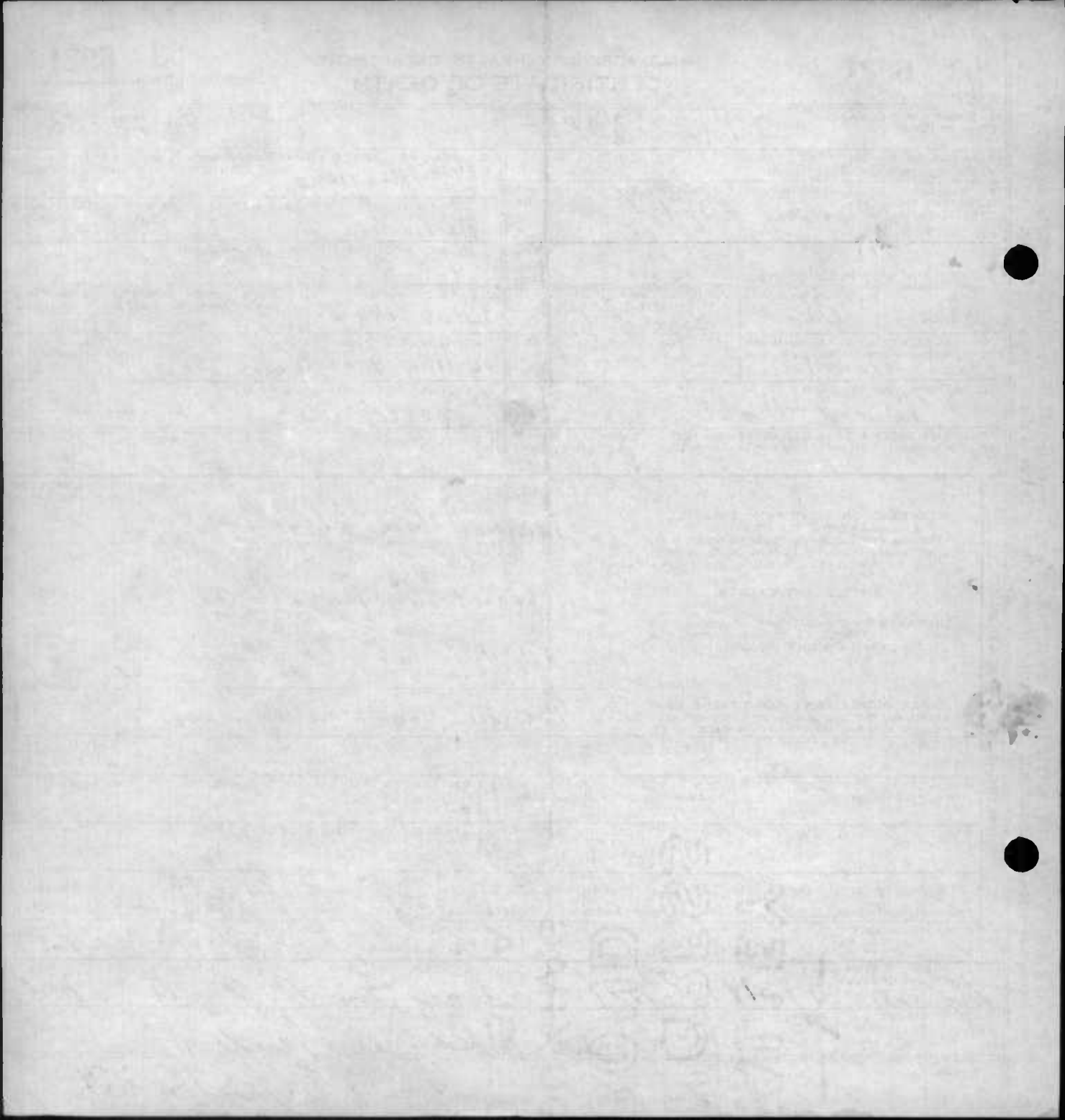
ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





M-460

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6922

53 6922

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Frank Muller

2. DATE  
OF  
DEATH

July 29-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Union Memorial Hospital

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

C. Length of stay in Baltimore

Mrs. Ella Muller

LIFE

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG 31-1869

9. AGE (In years  
last birthday)

83y

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SEA FOOD BUSINESS

10B. KIND OF BUSINESS OR  
INDUSTRY

SELF

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Muller

14. MOTHER'S MAIDEN NAME

ANNA. (UNKNOWN).

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

Ella Muller

ADDRESS

709 S. Bond St.

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Ca of COLON

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Subarachnoid Hemorrhage  
DUE TO  
(C) A.S.C.V.D.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7-23-53

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., lo or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from July 23, 1953, to July 29, 1953, that I last saw the deceased alive on July 29, 1953, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

S. A. D. - Berl

23B. ADDRESS

U. M. H

23C. DATE SIGNED

7-29-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

AUG 1 1953

24C. NAME OF CEMETERY OR CREMATORY

HOLY REDEEMER CEM

24D. LOCATION (City, town, or county)

4430 BELAIR RD MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 30 1953

Huntington Williams, M. D. Orpel Bros 1800 E LOMBARD ST

VS 150

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SAINT JOHN'S COLLEGE  
CERTIFICATE OF DEATH

|                        |  |                        |  |                      |  |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased       |  | Age                    |  | Sex                  |  |
| Residence              |  | Occupation             |  | Cause of Death       |  |
| Date of Death          |  | Time of Death          |  | Place of Death       |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Witness |  |
| Date of Certificate    |  | Time of Certificate    |  | Place of Certificate |  |

MAR-172342

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6923

BIRTH NO. 53 6923 46028

1. NAME OF DECEASED  
(Type or Print)

Clarence Warsaw

(Warson)

2. DATE  
OF  
DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)Baltimore City Hospitals  
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

23-01

D. STREET ADDRESS (If rural, give location)

134 West Cross St. #30

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

7-14-1953

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days

14

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clarence Warsaw

14. MOTHER'S MAIDEN NAME

Willie Mae Montgomery

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 763.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pneumonia, bilateral

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

4 1/4 hrs

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1953, to 7-28, 1953 that I last saw the  
deceased alive on 7-28, 1953, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

H. John Doe

M. D.

23B. ADDRESS

4940 Eastern Ave., Balto., Md. 7-28-53

23C. DATE SIGNED

24A. BURIAL, CREMA  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 30 1953

Huntington Williams, M.D.

J. Brown &amp; Son

108 W. Montgomery St.

VS 150

33 8-3

July 11, 1951

Shirley (Mrs.)

Shirley

Shirley (Mrs.)

Shirley

Shirley (Mrs.)

Shirley (Mrs.)

Shirley

Shirley (Mrs.)

Shirley

Shirley

Shirley

Shirley

Shirley (Mrs.)

Shirley (Mrs.)

Shirley (Mrs.)

Shirley

Shirley (Mrs.)

Shirley (Mrs.)

Shirley (Mrs.)

Shirley

Shirley (Mrs.)

Shirley (Mrs.)

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 53 6924

53 6924

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BRENT

ARMACOST

2. DATE  
OF  
DEATH

7-28-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence  
A. STATE B. COUNTY

MD.

20-07

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

ST. AGNES HOSP

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

3715 W. FRANKLIN ST.

D. STREET ADDRESS (If rural, give location)

BALTIMORE

c. Month of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

JULY 2, 1949

9. AGE (In years  
last birthday)

4

If Under 1 Year  
Months; DaysIf Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

RAYMOND ARMACOST.

14. MOTHER'S MAIDEN NAME

JESSIE NORMA PENCE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Raymond Armacost - 3715 W. Franklin St.

18. 759.3

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Cerebral Hemorrhage

7/28/53

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Multiple Congenital  
Anomalies & Defects

7/2/49

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Prematurity

7/2/49

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7/2, 1949 to 7/28, 1953 that I last saw the  
deceased alive on 7/27, 1953 and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1934

RECORDS OF THE

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3-430  
53 6925BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6925

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

Baltimore City, Maryland

4. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-27, 1953, to 7-29, 1953, that I last saw the deceased alive on 7-29, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25. FUNERAL RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

65-11

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-111111

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263  
6926BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6926

IRTH NO.

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| NAME OF DECEASED<br>(Type or Print) <b>CHARLES ECKHARDT</b>  |                                  | 2. DATE OF DEATH <b>JULY 28, 1953</b>   |                                    |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution / residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |                                    |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 23-03</b>                          |                                    |
| D. STREET ADDRESS (If rural, give location)<br><b>1707 HANOVER ST.</b>   |                                  | Yrs. of stay in Baltimore<br>Mos. Days  |                                    |
| SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b>  | 8. DATE OF BIRTH<br><b>1-18-06</b> |
| 9. AGE (In years last birthday)<br><b>47</b>   |                                  | 10. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>   | 11. CITIZEN OF WHAT COUNTRY?       |
| 12. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>APPROPRIATE</b>                  |                                  | 13. KIND OF BUSINESS OR INDUSTRY<br><b>ATLAS CO.</b>  |                                    |
| 14. FATHER'S NAME<br><b>HENRY ECKHARDT</b>   |                                  | 15. MOTHER'S MAIDEN NAME<br><b>RICKIE HEFFNER</b>   |                                    |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No.</b>                            |                                  | 17. SOCIAL SECURITY NO.   |                                    |
| 18. INFORMANT<br><b>FAMILY - JAMES</b>   |                                  | ADDRESS   |                                    |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>204.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>GASTRO-INTESTINAL BLEEDING</b><br>DUE TO<br><b>BLOOD DISEASE <del>LEUKEMIA</del> ALBURNIC TYPE</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |  |  |  |   |
|--|--|--|--|---|
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from <b>JULY 15</b> , 19 <b>53</b> , to <b>JULY 28</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>JULY 28</b> , 19 <b>53</b> , and that death occurred at <b>5:45 A. M.</b> , from the causes and on the date stated above. |  |  |  |   |
| 23A. SIGNATURE<br><b>Donald B. Bennett</b>   |  | 23B. ADDRESS<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b>  |  | 23C. DATE SIGNED<br><b>JULY 28, 1953</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B3.</b>  |  | 24B. DATE<br><b>7.30.53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN</b>                                |
| 24D. LOCATION (City, town, or county)<br><b>BALTO</b>  |  | 24E. FUNERAL DIRECTOR<br><b>Huntington Williams, James L. Keene</b>                                    |  |   |
| 24F. RECEIVED BY<br><b>VS 150</b>  |  | 24G. ADDRESS   |  |   |

59384

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

6927

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6927  
Registered No.

TH NO.

NAME OF DECEASED  
(Last, first, middle, or Print)

DAVID DODA

2. DATE  
OF  
DEATH 7/29/53

PLACE OF DEATH:

Baltimore City, Maryland 4700 Pennington Ave.

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 25-05D. STREET ADDRESS (If rural, give location)  
4116 Curtis Avenue

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE

USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)  
None7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
S

B. DATE OF BIRTH

II/3/42

9. AGE (In years, last birthday)  
1011 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.11. BIRTHPLACE (State or foreign country)  
Baltimore12. CITIZEN OF  
WHAT COUNTRY?

FATHER'S NAME

Milton Leo Doda

14. MOTHER'S MAIDEN NAME  
Sally M. GlinkaWAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

8. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
080.0 I  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH  
28 hrs.11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

9A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1953, to July 28, 1953, that I last saw the deceased alive on July 28, 1953, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

RECEIVED BY  
AL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

James L. McCully - 130 E. Fort Avenue

STATE OF NEW YORK  
CERTIFICATE OF DEATH

|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
|-----------------------|--|-----------------------|--|------------------------|--|--------------------|--|---------------------|--|----------------------|--|
| NAME OF DECEASED      |  | AGE                   |  | SEX                    |  | RACE               |  | DATE OF DEATH       |  | PLACE OF DEATH       |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| CAUSE OF DEATH        |  | MANNER OF DEATH       |  | OCCUPATION             |  | EDUCATION          |  | RELIGION            |  | MARITAL STATUS       |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESS  |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF CLERK |  | SIGNATURE OF JUDGE  |  | SIGNATURE OF SHERIFF |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| DATE OF BIRTH         |  | DATE OF DEATH         |  | DATE OF BURIAL         |  | DATE OF INTERMENT  |  | DATE OF CREMATION   |  | DATE OF REINTERMENT  |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| PLACE OF BIRTH        |  | PLACE OF DEATH        |  | PLACE OF BURIAL        |  | PLACE OF INTERMENT |  | PLACE OF CREMATION  |  | PLACE OF REINTERMENT |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| CITY OF DEATH         |  | COUNTY OF DEATH       |  | STATE OF DEATH         |  | CITY OF BURIAL     |  | COUNTY OF BURIAL    |  | STATE OF BURIAL      |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| CITY OF INTERMENT     |  | COUNTY OF INTERMENT   |  | STATE OF INTERMENT     |  | CITY OF CREMATION  |  | COUNTY OF CREMATION |  | STATE OF CREMATION   |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |
| CITY OF REINTERMENT   |  | COUNTY OF REINTERMENT |  | STATE OF REINTERMENT   |  | CITY OF CREMATION  |  | COUNTY OF CREMATION |  | STATE OF CREMATION   |  |
|                       |  |                       |  |                        |  |                    |  |                     |  |                      |  |



G-100  
MAF-172758

53 6928

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6928  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vincent Geppi

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3003 Oakford Ave. #15

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 2, 1947

9. AGE (In years  
last birthday)

5

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Geppi

14. MOTHER'S MAIDEN NAME

Josephine Baraman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18.

080.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pelionyelitis (bubba)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-27, 1953 to 7-29, 1953, that I last saw the  
deceased alive on 7-29, 1953, and that death occurred at 3:40P m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Johnson

M. D.

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

7-29-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

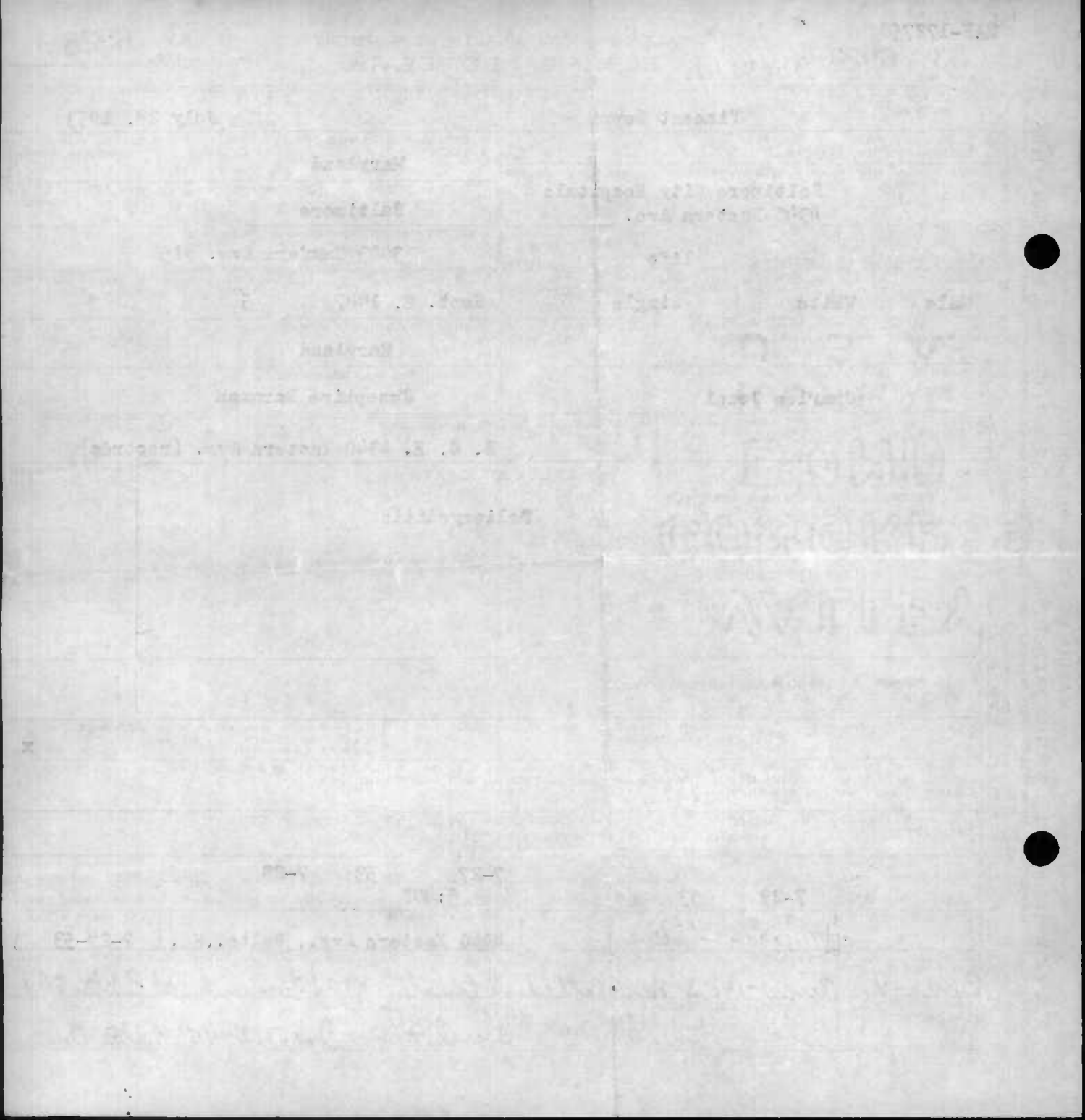
VS 150

Huntington Williams

Joseph Farace Inc. 712-14C North Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5-242  
53 6929BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6929  
Registered No.

IRTH NO.

|   |                              |  |  |
|---|------------------------------|--|--|
| NAME OF DECEASED<br>(Type or Print) <b>Schlossberg Frank</b>  |                              | 2. DATE OF DEATH<br><b>7/30/53</b>   |  |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Levensdale</b> B. COUNTY <b>Aged Home</b> |  |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>SPITAL OR INSTITUTION<br><b>Sinai Hospital</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>27-17</b>   |  |
| Length of stay in Baltimore<br><b>65</b> Yrs. Mos. Days   |                              | D. STREET ADDRESS (If rural, give location)<br><b>Green Spring Rd</b>  |  |
| SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>83</b>                              |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>   |                              | 10. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b> |
| FATHER'S NAME<br><b>Leor</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>Chunelga</b>  |  |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no or unknown</b>   |                              | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>David Schlossberg</b>          |
| 18. <b>585X and 260X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Overwhelming systemic infection</b> |                              | CAUSE OF DEATH<br>(A) <b>Overwhelming systemic infection</b><br>DUE TO<br>(B) <b>Acute cholecystitis</b><br>DUE TO<br>(C) <b>Pneumonia</b>     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Diabetes</b>  |                              | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION<br><b>0</b>  |                              | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                              | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                              | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>July 29, 1953</b> to <b>July 30, 1953</b> that I last saw the deceased alive on <b>July 30, 1953</b> and that death occurred at <b>8:55 A.M.</b> , from the causes and on the date stated above.            |                              |  |  |
| 23a. SIGNATURE<br><b>Samuel J. Abrams</b>   |                              | 23b. ADDRESS<br><b>5801 Green Spring Ave.</b>  |  |
| 23c. DATE SIGNED<br><b>7/30/53</b>  |                              |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                              | 24b. DATE<br><b>7-30-53</b>  |  |
| 24c. NAME OF CEMETERY OR CREMATORY<br><b>Beth T. Felson</b>   |                              | 24d. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>   |  |
| 25. FUNERAL DIRECTOR<br><b>Huntington Williams, Mr. Jack Lewis</b>  |                              | ADDRESS<br><b>2100 Cutaw Rd</b>  |  |
| 26. RECEIVED BY<br><b>30 1953</b>   |                              |  |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-623

53 6930

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6930  
Registered No.

BIRTH NO.

|  |                           |   |                                  |   |   |
|--|---------------------------|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)   |                           | Mrs. Mary Jane Freeman Christ   |                                  | 2. DATE OF DEATH<br>July 28, 1953                                 |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                                  |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>60 4700 Harford Road  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 26-01                         |                                  |   |   |
| c. Length of stay in Baltimore   |                           | D. STREET ADDRESS (If rural, give location)<br>4222 Berger Avenue   |                                  |   |   |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed  | 8. DATE OF BIRTH<br>Oct. 8, 1871 | 9. AGE (In years, last birthday)<br>81                            | If Under 1 Year<br>Months Days<br>If Under 24 Hours<br>Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home   |                           | 10B. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (State or foreign country)<br>Carroll Co. Maryland |   |
| 13. FATHER'S NAME<br>George W. Freeman   |                           | 14. MOTHER'S MAIDEN NAME<br>Helen Shorb   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                            |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                           | 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS<br>Mr. Harvey Christ, 4222 Berger Ave.      |   |

|   |                                     |  |                                  |
|---|-------------------------------------|--|----------------------------------|
| 18. 4201<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH                      |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | (A) Coronary Thrombosis             |  | 10 days                          |
|   | (B) Arteriosclerotic Cardio         |  | 28 April                         |
|   | (C) Vascular Disease & Hypertension |  | 1952                             |

|   |   |  |   |
|---|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                    |   |  |   |
| 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

|  |  |   |  |
|--|--|---|--|
| 22. I hereby certify that I attended the deceased from 28 April, 1953, to 28 July, 1953, that I last saw the deceased alive on 28 July, 1953, and that death occurred at 10:35 A.M., from the causes and on the date stated above. |  |   |  |
| 23A. SIGNATURE<br>E. W. Edwards  | 23B. ADDRESS<br>2746 The Alameda                   | 23C. DATE SIGNED<br>28 July 53                              |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  | 24B. DATE<br>July 31, 1953                         | 24C. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery     | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D. | 25. FUNERAL DIRECTOR<br>Leonard J. Ruck, 5305 Harford Road. |  |

VS 150

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

R-200  
53 6931

N.R.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 53 6931  
Registered No.

|   |                                  |  |   |                                     |  |   |  |  |
|---|----------------------------------|--|---|-------------------------------------|--|---|--|--|
| BIRTH NO.   |                                  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Martin Ross</b>  |                                     |  | 2. DATE OF DEATH<br><b>7-30-53</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> COUNTY <b>Adams</b> |                                     |  |   |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Agnes Hospital</b>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>52-00</b>  |                                     |  |   |  |  |
| c. Length of stay in Baltimore  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>Box 448A, Rt. 1, Crownsville, Md.</b>   |                                     |  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Infant</b> |   | 8. DATE OF BIRTH<br><b>11-16-52</b> |  | 9. AGE (In years, last birthday)<br><b>8 mos.</b>                             |  | 10. Under 1 Year<br>Months: Days: Hours: Min.                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |
| 13. FATHER'S NAME<br><b>Martin E. Ross</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Grier</b>  |                                     |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |                                  |  | 16. SOCIAL SECURITY NO.   |                                     |  | 17. INFORMANT ADDRESS<br><b>Martin E. Ross to Annapolis, Md.</b>              |  |  |
| 18. <b>490X</b>   |                                  |  | CAUSE OF DEATH  |                                     |  |   |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |                                  |  | (A) <b>Lobar pneumonia, bilateral</b>   |                                     |  |   |  |  |
| ANTECEDENT CAUSES   |                                  |  | (B) _____   |                                     |  |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  |  | (C) _____   |                                     |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  | <b>Hydrocephalus, cong. cleft palate</b>  |                                     |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II        |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?      |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |                                     |  | 21F. HOW DID INJURY OCCUR?  |  |  |
| 22. I hereby certify that I attended the deceased from <b>July 1, 1953</b> to <b>July 30, 1953</b> that I last saw the deceased alive on <b>July 30, 1953</b> and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above. |                                  |  |   |                                     |  |   |  |  |
| 23A. SIGNATURE<br><b>James E. Rowe Jr.</b>  |                                  |  | 23B. ADDRESS<br><b>St. Agnes Hosp.</b>  |                                     |  | 23C. DATE SIGNED<br><b>7/30/53</b>  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  |  | 24B. DATE<br><b>July 31/53</b>  |                                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>                       |  |  |
| 24D. LOCATION (City, town, or county)<br><b>Glen Burnie, Md.</b>  |                                  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><b>Glen Burnie, Md.</b>   |                                     |  | 24F. LOCATION (City, town, or county)<br><b>Glen Burnie, Md.</b>              |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 30 1953</b>   |                                  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |                                     |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>B. E. Hopping &amp; Son Annapolis, Md.</b> |  |  |

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-200  
53 6932

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

53 6932  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Edward S. Reese</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 29, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>3035 W. North Ave.,</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                |  |   |
| c. Length of stay in Baltimore<br>80- Yrs.<br>Mos.<br>Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>3035 W. North Ave.,</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b> | 8. DATE OF BIRTH<br><b>Nov. 3, 1872</b>   |  | 9. AGE (in years, last birthday)<br><b>80</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stair Builder</b>                      |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b> |
| 13. FATHER'S NAME<br><b>George Reese</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Laura J. Atkinson</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>217-22-1708</b>   |  |   |
|  |                                  |   | 17. INFORMANT<br><b>Sophonria A. Allen</b>  |  |   |
|  |                                  |   | ADDRESS<br><b>3035 W. North Ave.</b>  |  |   |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. <b>420.1.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Sclerosis</b>        |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Senility</b>   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1953</b> to <b>July 25, 1953</b> , that I last saw the deceased alive on <b>July 29, 1953</b> , and that death occurred at <b>5:30 p.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>[Signature]</i>  |  | 23B. ADDRESS<br><b>3035 W. North Ave.</b>   |  | 23C. DATE SIGNED<br><b>7-30-53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>8-1-1953</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore, Md.</b>                         |  |
| DATE RECEIVED BY<br><b>30 1953</b>  |  | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  | 25. FUNERAL DIRECTOR'S ADDRESS<br><b>G. Howard Strong 3207 W. North Ave.,</b>       |  |

Dr. Beyerly

July 25, 1955

Edward A. Weiss

1000 N. North Ave.

Beltsville

MD

2-100 N. North Ave.

Beltsville

Beltsville

Beltsville

Beltsville

MD

Beltsville

Beltsville

Edward A. Weiss

Edward A. Weiss

MD-1-1705

MD

MD

Beltsville

Beltsville

MD-1-1705

Beltsville

Edward A. Weiss

CERTIFICATE AMENDED 12/10/53 ES

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

MAF-172480

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Agostino or Augustine Russo

2. DATE  
OF  
DEATH

July 28, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

211 S. High St.

c. Length of stay in Baltimore

40 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 18, 1889

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

JANITOR

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Antonino Russo

14. MOTHER'S MAIDEN NAME

Mary Boiravolo

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-14-1419

17. INFORMANT

ADDRESS

B. C. H. 4940 Eastern Ave. (records)

18. 434.3

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute Heart Failure

DUE TO

## ANTECEDENT CAUSES

(B) Pulmonary Edema

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE, (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Cardiac dilatation, myocardial scarring, diffus  
r. ventricular hypertrophy, bilat. obliteration  
of the pleural space, etc.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20, 1953, to 7-28, 1953, that I last saw the  
deceased alive on 7-28, 1953, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE

J. J. John Doe, M. O.

23B. ADDRESS

4940 Eastern Ave., Balto., Md.

23C. DATE SIGNED

7-28-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 31st/53 Holy Redeemer Cem.

4430 Belair Rd. Balt. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D. Frank DeLoe 322 S. High St.

VS 150

77074

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PENNLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For complete P.A.D. see query reply in Document file.



F-642  
53 6934

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6934

IRTH NO.

NAME OF DECEASED (Type or Print) **OLIVE FROENLICH**

2. DATE OF DEATH **July 28, 1953**

PLACE OF DEATH: **Baltimore City, Maryland BALTO. CITY**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **MARYLAND**  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **BALTIMORE 1-01**  
D. STREET ADDRESS (If rural, give location) **2945 HUDSON ST**

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
**LIFE 2945 HUDSON ST**

Length of stay in Baltimore  
Yrs. **0**  
Mos. **0**  
Days **0**

SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWED**

8. DATE OF BIRTH **SEPT. 8 1890** 9. AGE (In years last birthday) **62**

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) **HOUSE WORK** 10B. KIND OF BUSINESS OR INDUSTRY **HOUSE WORK**

11. BIRTHPLACE (State or foreign country) **BALTIMORE MD.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A**

FATHER'S NAME **JOSEPH B. STOKES** 14. MOTHER'S MAIDEN NAME **MARY E. CRISP**

13. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **219-22-3146** 17. INFORMANT **EARL FROENLICH** ADDRESS **2114 BOYD ST**

18. **4-20-1** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Hypertensive C.V. Disease.**  
DUE TO  
(A) **Acute Coronary Thrombosis**  
(B) **Acute Coronary Occlusion**  
(C) **None**

INTERVAL BETWEEN ONSET AND DEATH  
**6-26-53**  
**7-28-53**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**None**

19A. DATE OF OPERATION **None** 19B. MAJOR FINDINGS OF OPERATION **None** 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH **None** 21B. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) **None** 21C. WHERE DID INJURY OCCUR **None**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **None** 21E. INJURY OCCURRED WHILE AT WORK ☐ OR WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? **None**

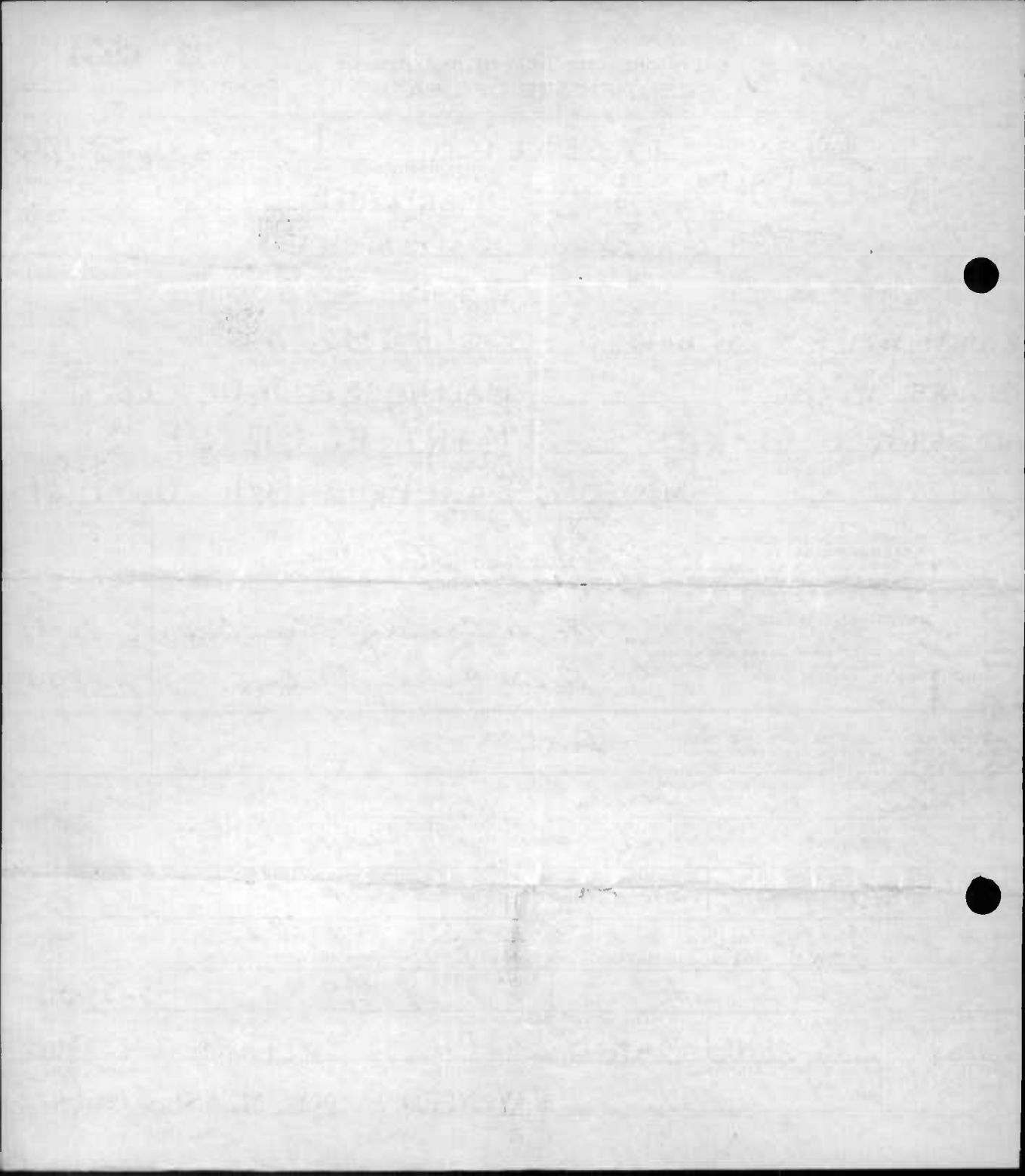
22. I hereby certify that I attended the deceased from **6-26-53** 19, to **7-28-53** 19, that I last saw the deceased alive on **7-25**, 1953, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE **E. A. Schimmuck** M. D. 23B. ADDRESS **8428 E. 9 Ave** 23C. DATE SIGNED **7-29-53**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24B. DATE **July 31, 1953** 24C. NAME OF CEMETERY OR CREMATORY **OAK Lawn Cem.** 24D. LOCATION (City, town, or county) (State) **EASTERN MD.**

25. FUNERAL DIRECTOR **WENDELL J. DIPPEL** ADDRESS **312 S. Highland Ave**

RECEIVED BY **Huntington Williams, Jr.** VS 150



K-550  
53 6935BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6935  
Registered No.

RTH NO.

|   |                                     |   |   |   |   |
|---|-------------------------------------|---|---|---|---|
| NAME OF DECEASED<br>Type or Print <i>Katherine A. Keenan</i>  |                                     |   | 2. DATE OF DEATH<br><i>July 30-53</i>   |   |   |
| PLACE OF DEATH:<br>Baltimore City, Maryland   |                                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i><br>B. COUNTY <i>Baltimore</i> |   |   |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>5625 Midwood Ave</i> |                                     |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-38</i>                                    |   |   |
| Length of stay in Baltimore <i>1 yr</i>   |                                     |   | D. STREET ADDRESS (If rural, give location)<br><i>5625 Midwood Ave</i>  |   |   |
| SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>A. White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i> | 8. DATE OF BIRTH<br><i>Apr 15-</i>  | 9. AGE (In years last birthday)<br><i>70</i>                | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)<br><i>home</i>                   |                                     | 10. B. KIND OF BUSINESS OR INDUSTRY                               |   | 11. BIRTHPLACE (State or foreign country)<br><i>Ireland</i> |   |
| FATHER'S NAME<br><i>Michael Curran</i>  |                                     |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>Ireland</i>  |   |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>no or unknown</i>           |                                     |   | 16. SOCIAL SECURITY NO.<br><i>-</i>   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>  |                                     |   | 17. INFORMANT<br><i>Eileen M Murphy</i>   |   |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <i>141X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br>(A) <i>Carcinoma of 1/ upper</i><br>DUE TO<br>(B) <i>c m metastasis</i><br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |
|---|--|--|
| 19A. DATE OF OPERATION<br><i>0</i>  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from *March*, 1953 to *July*, 1953 that I last saw the deceased alive on *July 30*, 1953, and that death occurred at *11:30 A.* from the causes and on the date stated above.

|  |  |   |
|--|--|---|
| 23A. SIGNATURE<br><i>William J. Murphy</i>           | 23B. ADDRESS<br><i>913 E. Belvedere</i>                    | 23C. DATE SIGNED<br><i>7-30-53</i>                            |
| A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>B</i>  | 24B. DATE<br><i>Aug 3-53</i>                               | 24C. NAME OF CEMETERY OR CREMATORY<br><i>St Pauls</i>         |
| TE RECEIVED BY<br>CAL REGISTRAR<br><i>31 30 1953</i> | REGISTRAR'S SIGNATURE<br><i>H. Kingston Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>Frank A. S. City 814 N 36th St</i> |



M-625

53 6936

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6936  
Registered No.

IRTH NO.

NAME OF DECEASED  
(Type or Print)

CURTIS G. MORGAN

2. DATE  
OF  
DEATH

July 29, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)

SINAI HOSPITAL &amp; BALTO., INC.

Length of stay in Baltimore

2

SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10a. USUAL OCCUPATION (Give kind of  
done during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR  
INDUSTRY

SHIP CONSTR.

FATHER'S NAME

CHARLIE MORGAN

11. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

015-24-8308

B. DATE OF BIRTH

3-19-1880

9. AGE (in years  
last birthday)

73

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

LAURA PLUMMER

17. INFORMANT

ADDRESS

LULA MORGAN - SAME

18.

241X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INSUFFICIENCY

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) CHRONIC EMPHYSEMA

DUE TO

(C) ASTHMA

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/29, 1953, to 7/29, 1953, that I last saw the  
deceased alive on 7/29, 1953, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

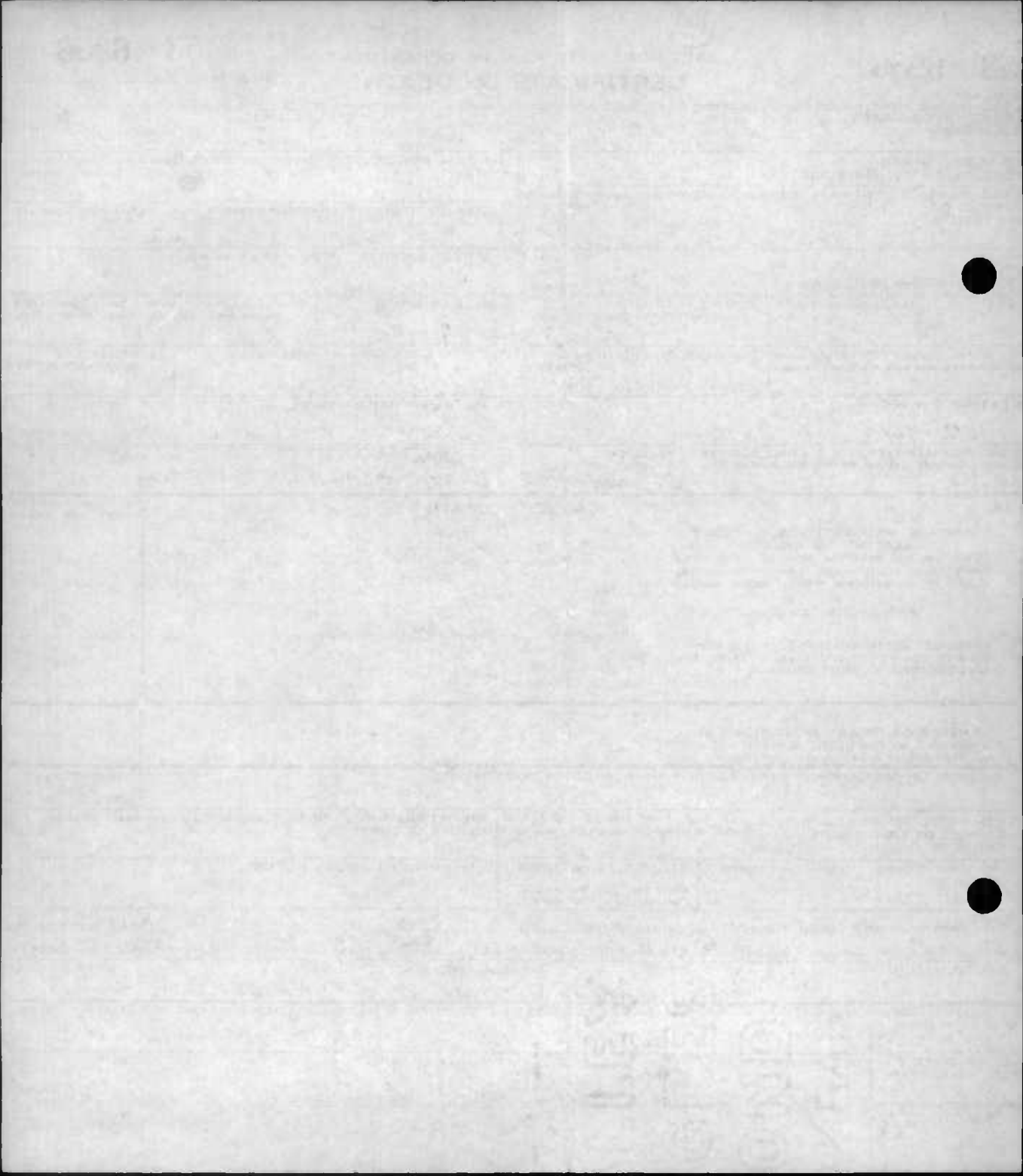
ADDRESS

Huntington Williams, M.D.

Walter Brooks Bradley - Dundalk, Md.

VS 150

69055





3-500

53 6937

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6937  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Josias Bowen

2. DATE  
OF  
DEATH

July 29-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore

Yrs.  
Mos.  
DaysD. SEX  
maleE. COLOR OR RACE  
whiteF. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)G. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Broken up Ret

H. B. KIND OF BUSINESS OR  
INDUSTRY

I. FATHER'S NAME

Josias S Bowen

J. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)K. SOCIAL  
SECURITY NO.L. 4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

M. STATE

N. COUNTY

O. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 27-06

P. D. STREET ADDRESS (If rural, give location)

5500 Moreels Rd.

Q. 8. DATE OF BIRTH

6-15-79

R. 9. AGE (In years  
last birthday)

74

S. If Under 1 Year  
Months DaysT. If Under 24 Hours  
Hours Min.

U. 11. BIRTHPLACE (State or foreign country)

Md

V. 12. CITIZEN OF  
WHAT COUNTRY?

W. 14. MOTHER'S MAIDEN NAME

Ida E Turner

X. 17. INFORMATION  
JOHNS HOPKINS HOSPITAL ADDRESS

Y. 18. 331X I

Z. CAUSE OF DEATH

AA. INTERVAL BETWEEN  
ONSET AND DEATHAB. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

AC. (A) Cerebral hemorrhage

AD. 3 days

AE. ANTECEDENT CAUSES

AF. DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

AG. (B) Arteriosclerosis

AH. ca 10 yrs

AI. OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

AJ. Benign prostatic hypertrophy

AK. 19A. DATE OF OPERATION

AL. 19B. MAJOR FINDINGS OF OPERATION

AM. 20. AUTOPSY?

AN. YES ☐ NO ☐AO. 21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATHAP. 21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)AQ. 21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)AR. 21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

AS. 21E. INJURY OCCURRED

AT. 21F. HOW DID INJURY OCCUR?

AU. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORKAV. 22. I hereby certify that I attended the deceased from 7-14, 1953, to 7-29, 1953, that I last saw the  
deceased alive on 7-29, 1953, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

AW. 23A. SIGNATURE

AX. 23B. ADDRESS

AY. 23C. DATE SIGNED

AZ. William A. Campbell M.D.

BA. JOHNS HOPKINS HOSPITAL

BB. 7/29/53

BC. 24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BD. 24B. DATE

BE. 24C. NAME OF CEMETERY OR CREMATORY

BF. 24D. LOCATION (City, town, or county) (State)

BG. DATE RECEIVED BY  
LOCAL REGISTRAR

BH. REGISTRAR'S SIGNATURE

BI. 25. FUNERAL DIRECTOR

BJ. ADDRESS

BK. 31 1953

BL. H. Antington Williams, M.D. 2112 Dundalk Ave

VS 150

310 99



MARGIN RESERVED FOR BINDING

PLEASE WRITE PEN ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4-643  
AB-143814  
53 6938

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6938  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph John Herold

2. DATE  
OF  
DEATH

7-29-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (if not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Baltimore City Hospitals-4940 Eastern Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Div.

8. DATE OF BIRTH

Nov. 9-1893

9. AGE (In years last birthday)

59

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Herold

14. MOTHER'S MAIDEN NAME

Ida Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-10-972

17. INFORMANT ADDRESS

4940 Eastern Ave. Baltimore City Hospitals

18. DOX

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Pneumonia

DUE TO

ANTECEDENT CAUSES

(B) Post Operative Hemothorax

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7-28-1953

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Pulmonary Thoracoplasty for Tuberculosis

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-25-1951 to 7-29-1953, that I last saw the deceased alive on 7-29-1953, and that death occurred at 2:30AM, from the causes and on the date stated above.

23A. SIGNATURE

H. John Herold

M. D.

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

7-29-1953

23D. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Aug 1/53

24C. NAME OF CEMETERY OR CREMATORY

Cook Lawn Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Philip's Newiglow

ADDRESS

2024 Orleans St

VS 150

574-24

31

13-10000

13-10000

13-10000

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13-10000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

R-324

CERTIFICATE CORRECTED 9-7-53

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6939

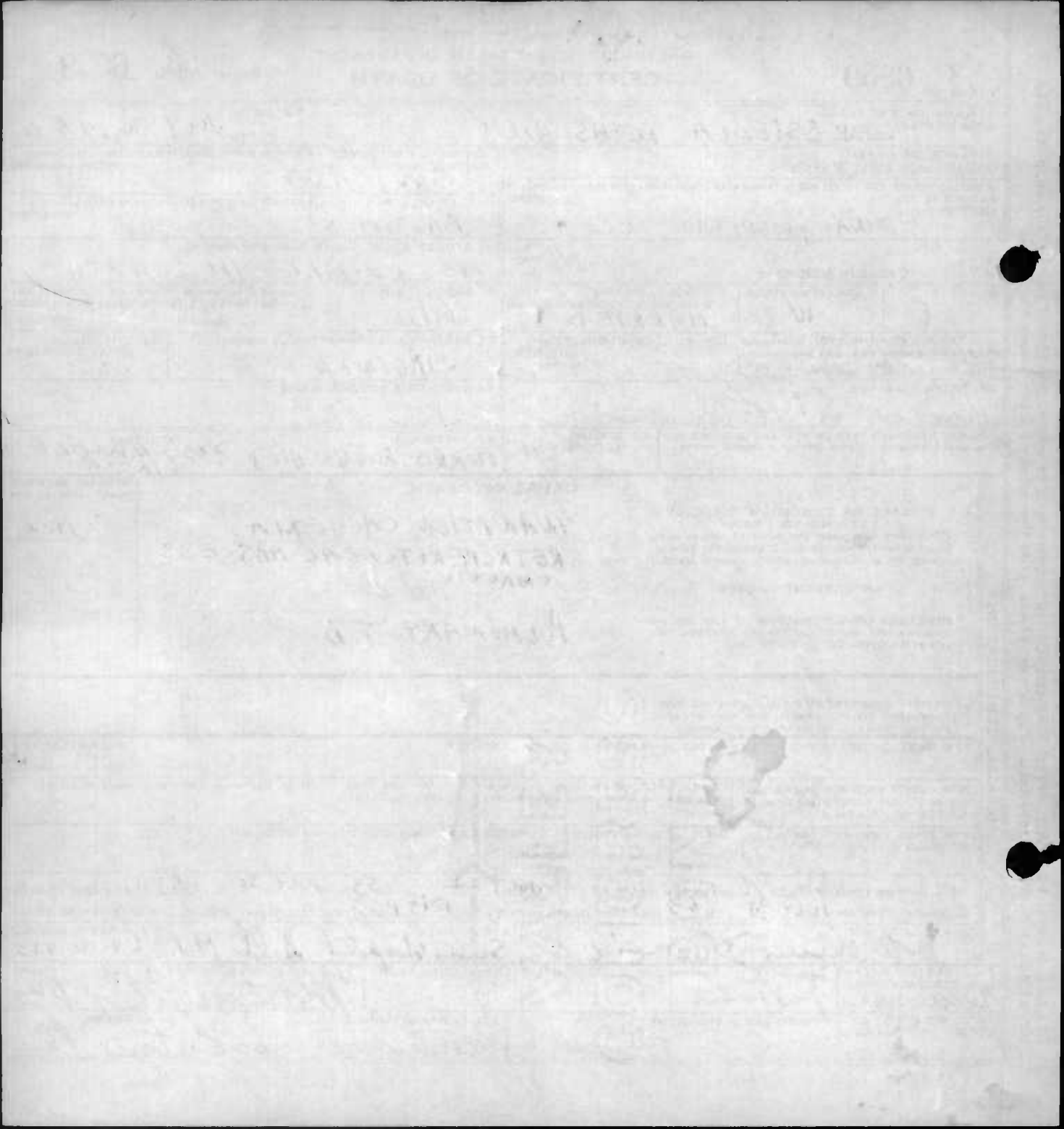
53 6939  
BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) SARAH ESTELLA ROTHSCHILD   |  | 2. DATE OF DEATH JULY 30, 1953   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION SINAI HOSPITAL, INC |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE 27-16                      |  |
| D. STREET ADDRESS (If rural, give location)<br>2855 EDMOND CIRCLE NORTH   |  | 5. SEX F 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED                                  |  |
| 8. DATE OF BIRTH 6/4/21   |  | 9. AGE (In years last birthday) 32   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife                              |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA  |  | 12. CITIZEN OF WHAT COUNTRY? USA   |  |
| 13. FATHER'S NAME James R. Bauer  |  | 14. MOTHER'S MAIDEN NAME Julia M.  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT MORRIS ROTHSCHILD   |  | ADDRESS 2855 EDMOND CIRCLE   |  |

MEDICAL CERTIFICATION

|   |  |   |
|---|--|---|
| 18. 002X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>INANITION, CACHEXIA,<br>RETROPERITONEAL ABSCESS,<br>CHRONIC<br>PULMONARY T.B. |  | INTERVAL BETWEEN ONSET AND DEATH<br>7. Mos. |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION 0   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from JULY 22, 1953 to JULY 30, 1953, that I last saw the deceased alive on JULY 30, 1953, and that death occurred at 245 P.m., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE William D. Dornie M.D.  |  | 23B. ADDRESS Sinai Hospital Balt. Md.  |  | 23C. DATE SIGNED July 30, 1953   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Removal  |  | 24B. DATE 7-31-53  |  | 24C. NAME OF CEMETERY OR CREMATORY   |  |
| 24D. DATE RECEIVED BY LOCAL REGISTRAR  |  | 24E. REGISTRAR'S SIGNATURE   |  | 24F. LOCATION (City, town, or county) (State) Martinsville, Va.                  |  |
| 25. FUNERAL DIRECTOR   |  | ADDRESS 2100 Eutaw Pl  |  |  |  |





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6940  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**KAPLAN, WILLIAM**

2. DATE  
OF  
DEATH

**7-30-53**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION **SINAI HOSP.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

**MARYLAND**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**BALTIMORE 27-18**

D. STREET ADDRESS (If rural, give location)

**5444 JONQUIL AVE - 15**

5. Length of stay in Baltimore

**50** Yrs.  
Mons.  
Days

6. SEX 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**M**

**W**

**M**

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.

**71**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Taylor**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Russia**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Russan**

14. MOTHER'S MAIDEN NAME

**Serna**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Frieda Kaplan - Same**

18. **570.3**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **PNEUMONITIS**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **ATELECTASIS**

DUE TO

(C) **VOLVULUS OF SIGMOID**

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

**VOLVULUS OF SIGMOID**

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **7-30**, 19**53**, to **7-30**, 19**53**, that I last saw the deceased alive on **7-30**, 19**53**, and that death occurred at **3:20 P** m., from the causes and on the date stated above.

23A. SIGNATURE

**Samuel Blumenfeld** M. D.

23B. ADDRESS

**Sinai Hosp**

23C. DATE SIGNED

**7-30-53**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**7-31-53**

24C. NAME OF CEMETERY OR CREMATORY

**Hebrew Young men**

24D. LOCATION (City, town, or county)

**Balto Md**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams**

25. FUNERAL DIRECTOR

**James Kewin**

ADDRESS

**7100 Eutan Pl**

VALLEY  
CO. INC.

4-435

53 6941

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6941

|  |                                   |   |   |   |   |  |                               |
|--|-----------------------------------|---|---|---|---|--|-------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JEANNE ELIZABETH HOLDEN</b>  |                                   |   |   | 2. DATE OF DEATH <b>JULY 30, 1953</b>   |   |  |                               |
| 3. PLACE OF DEATH:<br>Baltimore City, Maryland   |                                   |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY |   |  |                               |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>KENESAW REST HOME</b>   |                                   |   |   | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 12 53-00</b>                   |   |  |                               |
| 7. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                   |   |   | 8. STREET ADDRESS (If rural, give location)<br><b>6306 BELLONA AVENUE</b>   |   |  |                               |
| 9. SEX<br><b>FEMALE</b>  | 10. COLOR OR RACE<br><b>WHITE</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>  | 12. DATE OF BIRTH<br><b>DEC. 27, 1868</b> |   | 13. AGE (In years last birthday)<br><b>84</b> |  | 14. Under 1 Year Months: Days |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                   | 16. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |   | 17. BIRTHPLACE (State or foreign country)<br><b>DELAWARE</b>  |   | 18. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                               |
| 19. FATHER'S NAME<br><b>ADAMS MAHOOD</b>   |                                   |   |   | 20. MOTHER'S MAIDEN NAME<br><b>CATHARINE MITCHELL</b>   |   |  |                               |
| 21. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>   |                                   | 22. SOCIAL SECURITY NO.<br><b>NONE</b>  |   | 23. INFORMANT ADDRESS<br><b>Dr. F. A. HOLDEN 6306 BELLONA AVE. BALTO. 12, MD.</b>   |   |  |                               |
| 18. <b>332X I</b>  |                                   |   |   | CAUSE OF DEATH  |   |  |                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                                   |   |   | (A) <b>Terminal bronchopneumonia</b>  |   |  |                               |
| ANTECEDENT CAUSES  |                                   |   |   | DUE TO  |   |  |                               |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                   |   |   | (B) <b>Pulmonary oedema</b>   |   |  |                               |
|  |                                   |   |   | DUE TO <b>Cerebral Thromboses</b>   |   |  |                               |
|  |                                   |   |   | <b>arteriosclerosis</b>   |   |  |                               |
|  |                                   |   |   | (C) <b>Generalized arteriosclerosis</b>   |   |  |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                   |   |   | <b>None.</b>  |   |  |                               |
| 19A. DATE OF OPERATION<br><b>None.</b>   |                                   | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |                               |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>None</b>  |                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |  |                               |
| 22. I hereby certify that I attended the deceased from <b>1945</b> , to <b>July 30</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 29, 1953</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above. |                                   |   |   |   |   |  |                               |
| 23A. SIGNATURE<br><b>Robert N. Knight</b>  |                                   |   |   | 23B. ADDRESS<br>M. D. <b>Medical Art Bldg.</b>  |   | 23C. DATE SIGNED<br><b>July 31-1953</b>  |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                   | 24B. DATE<br><b>AUG 1, 1953</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>CHURCHHILL CEMETERY</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>CHURCHHILL, QUEEN ANNES, MD.</b> |                               |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 31 1953</b>   |                                   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Jr.</b>  |   | 25. FUNERAL DIRECTOR<br><b>John B. B. Sore, Jackson, Md.</b>  |   | ADDRESS  |                               |

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NO. 100

|                       |  |                              |  |
|-----------------------|--|------------------------------|--|
| Name of Deceased      |  | Date of Death                |  |
| Sex                   |  | Age                          |  |
| Place of Birth        |  | Usual Residence              |  |
| Cause of Death        |  | Manner of Death              |  |
| Physician's Signature |  | Medical Examiner's Signature |  |
| Date of Certificate   |  | Place of Death               |  |

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6942  
Registered No.

4  
53 6942  
BIRTH NO.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William C. Schmidt Jr.</b>   |                                  |   | 2. DATE OF DEATH<br><b>July 29/53</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location)<br><b>Union Memorial Hospital<br/>Calvert &amp; 33rd Sts.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Arbutus</b>                                      |  |   |
| c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>125 Waelchli Ave. 53-51</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Sept. 3, 1914</b>  | 9. AGE (In years last birthday)<br><b>38</b>                   | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Office Clerk</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balmar Corp.</b>          |   | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b> |   |
| 13. FATHER'S NAME<br><b>Wm. C. Schmidt, Sr.</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>218 18 6020</b>   |  |   |
| 17. INFORMANT<br><b>Mrs. Aldona Schmidt</b>  |                                  |   | ADDRESS<br><b>125 Waelchli Ave</b>  |  |   |

|  |  |  |
|--|--|--|
| 18. <b>416 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Cardiac failure</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b> |
| DUE TO   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Rheumatic heart disease, as a child</b>   |  |  |
| DUE TO   |  |  |
| (C)  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from Jan, 1951, to July 26, 1952, that I last saw the deceased alive on July 26, 1952, and that death occurred at m., from the causes and on the date stated above.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 23A. SIGNATURE<br><b>Charles Tommasello</b>                |  | 23B. ADDRESS<br><b>900 W. Lombard St.</b>           |  | 23C. DATE SIGNED<br><b>July 31/52</b>                                     |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>Aug. 1/53</b>                       |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                  |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore 29, Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>July 31 1953</b>    |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> |  | 25. FUNERAL DIRECTOR<br><b>Harry A. Wintz</b>                             |  |
|  |  |   |  | ADDRESS<br><b>101 Edmondson Ave</b>                                       |  |

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

at \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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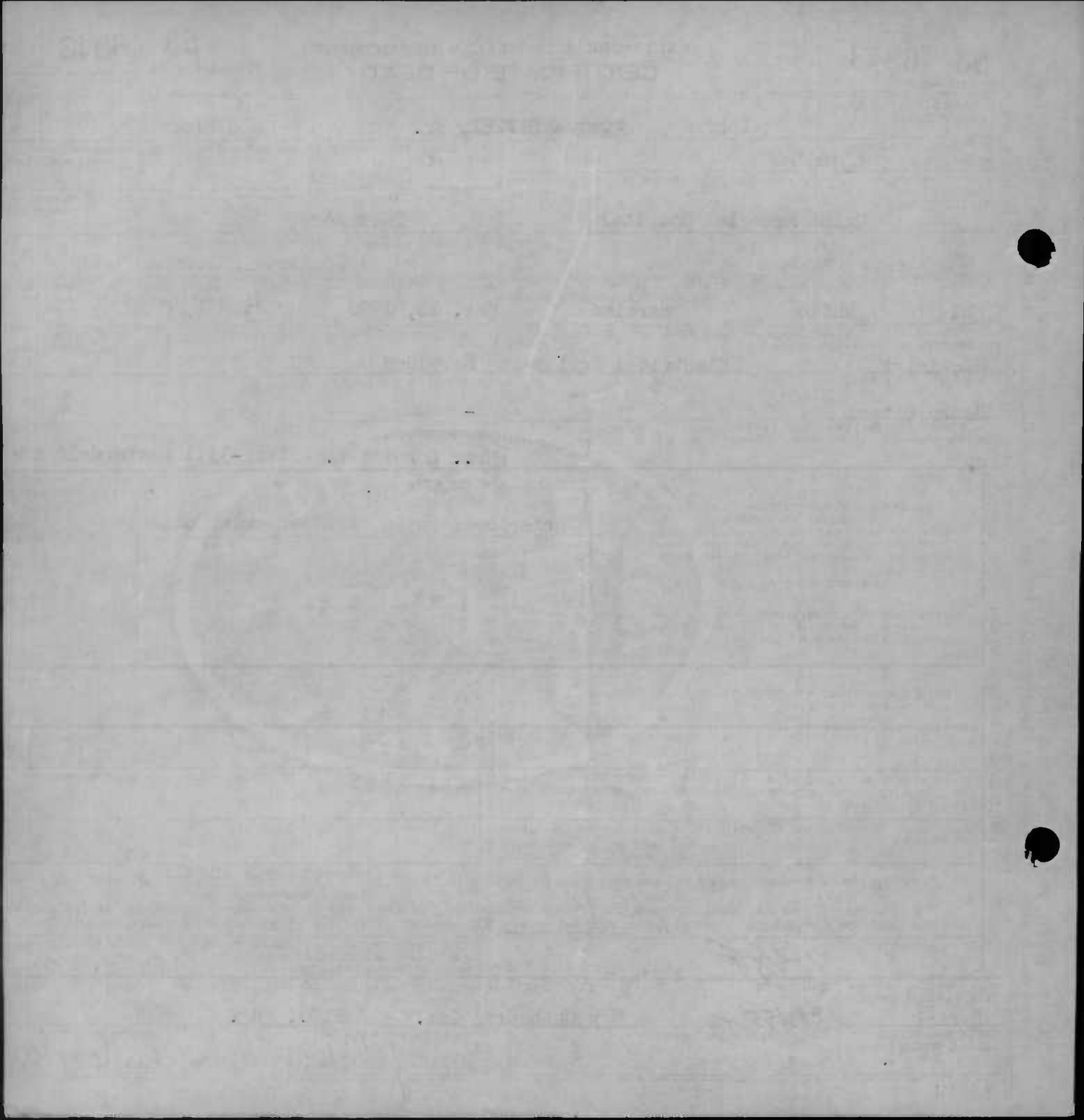
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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6943  
Registered No.

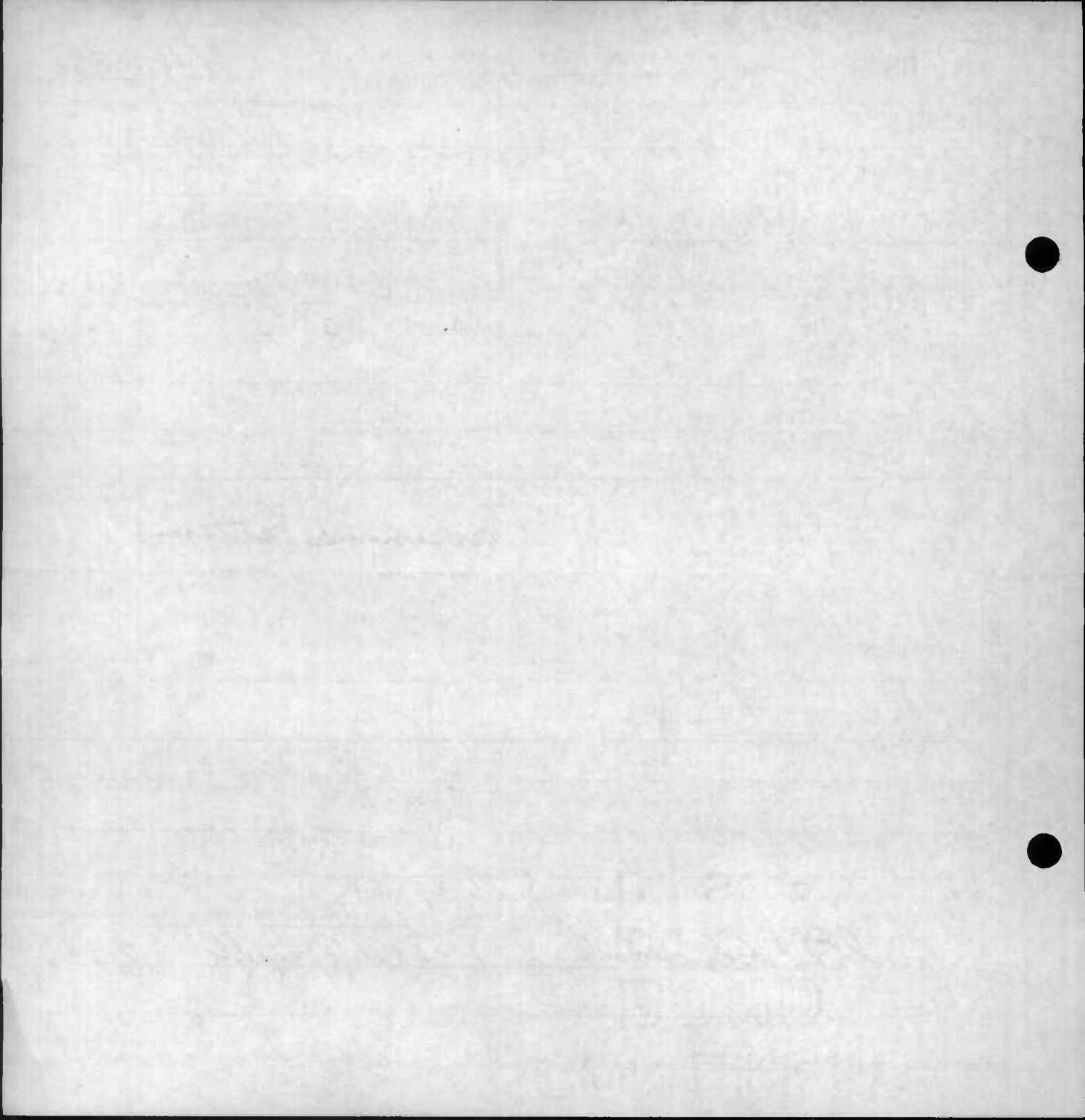
|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.<br>53 6943   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 53 6943<br>Registered No.   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>WILLIAM ELMER DITZEL, Sr.</b>   |  |   | 2. DATE OF DEATH<br><b>July 29, 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>  |  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 7-03</b>                          |   |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |  |   | D. STREET ADDRESS (If rural, give location)<br><b>3311 Westerwald Avenue</b>   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>             | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>   | 8. DATE OF BIRTH<br><b>Mar. 16, 1900</b>   | 9. AGE (In years last birthday)<br><b>53</b>  | 10. Under 1 Year Months Days 11 Under 24 Hours Hours Min.    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Electrical Equipment</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   | 13. FATHER'S NAME<br><b>Henry Ditzel</b>   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>-</b>   |  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>          |   |  |
| 16. SOCIAL SECURITY NO.  |  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Loretta L. Ditzel-3311 Westerwald Ave</b>   |   |  |
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) DUE TO<br>ANTECEDENT CAUSES<br>(B) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH                             |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>R. F. Fisher</b>  |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 29, 1953</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>8/3/53</b>                   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Jul 31 1953</b>   | REGISTRAR'S SIGNATURE<br><b>H. H. Fisher</b> | 25. FUNERAL DIRECTOR<br><b>Wm. J. Fisher &amp; Sons</b>   |  | ADDRESS<br><b>Balto 17 Md</b>   |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

|   |                       |   |                                 |  |                              |
|---|-----------------------|---|---------------------------------|--|------------------------------|
| 53 6944   |                       | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |                                 | 53 6944<br>Registered No.  |                              |
| BIRTH NO.   |                       | 1. NAME OF DECEASED<br>(Type or Print)  |                                 | 2. DATE OF DEATH   |                              |
|   |                       | DAISY A. BRITTON  |                                 | July 29, 1953  |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                       | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Md. |                                 |  |                              |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>3405 Lynchester Rd.  |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore             |                                 |  |                              |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                       | D. STREET ADDRESS (If rural, give location)<br>3405 Lynchester Rd. 15-11                              |                                 |  |                              |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed  | 8. DATE OF BIRTH<br>Jan. ? 1863 | 9. AGE (In years, last birthday)<br>90                                   | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Home   |                       | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home   |                                 | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.              |                              |
| 13. FATHER'S NAME<br>Capt. Littleton Long   |                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                 |  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>No  |                       | 16. SOCIAL SECURITY NO.<br>None   |                                 | 14. MOTHER'S MAIDEN NAME<br>Kate Tucker                                  |                              |
| 17. INFORMANT<br>Mrs. Alice Arthur  |                       | ADDRESS<br>3405 Lynchester Rd.  |                                 |  |                              |
| 18. 154X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(C) |                       | CAUSE OF DEATH<br>Carcinoma Rectum  |                                 | INTERVAL BETWEEN ONSET AND DEATH   |                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                       |   |                                 |  |                              |
| 19A. DATE OF OPERATION  |                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 | 19C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)              |                                 | 21F. HOW DID INJURY OCCUR?   |                              |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                       | 21E. INJURY OCCURRED<br>WHILE AT WORK NOT WHILE AT WORK   |                                 |  |                              |
| 22. I hereby certify that I attended the deceased from July 29, 1953, to , 19 , that I last saw the deceased alive on 19 , and that death occurred at m., from the causes and on the date stated above.   |                       |   |                                 |  |                              |
| 23A. SIGNATURE<br>Milton Seacink  |                       | 23B. ADDRESS<br>1729 W. Jay St.   |                                 | 23C. DATE SIGNED<br>7/30/53  |                              |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                       | 24B. DATE<br>7/31/53  |                                 | 24C. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery                |                              |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Md.   |                       | 24E. LOCATION (City, town, or county)<br>Baltimore, Md.   |                                 | 24F. LOCATION (City, town, or county)<br>Baltimore, Md.                  |                              |
| DATE RECEIVED BY LOCAL REGISTRAR<br>31 1953   |                       | REGISTRAR'S SIGNATURE<br>Huntington Williams  |                                 | 25. FUNERAL DIRECTOR<br>Wm. J. Tucker & Sons, Inc.                       |                              |
| VS 150  |                       | ADDRESS<br>Baltimore, Md.   |                                 |  |                              |



correct age is especially important. Physicians: please write the exact date of birth and date of death.

W-623  
53 6945

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6945  
Registered No.

BIRTH NO.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Alice Lee Wright</u>  |                                  |   | 2. DATE OF DEATH <u>7-30-53</u>  |  |   |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Mo.</u> B. COUNTY <u>Balto.</u> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hospital</u>                                       |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><u>Baltimore</u> <u>12-03</u>                       |  |   |
| C. Length of stay in Baltimore <u>Several Years</u>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><u>330 E. 28th St.</u>  |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Widowed</u> | 8. DATE OF BIRTH<br><u>Feb 18, 1878</u>  |  | 9. AGE (In years last birthday)<br><u>75</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Wholesale China</u>       | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13. FATHER'S NAME<br><u>Richard S. Catlett</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary A. Oliver</u>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>No</u>                                  |                                  | 16. SOCIAL SECURITY NO.<br><u>216-03-8288</u>                     | 17. INFORMANT ADDRESS<br><u>Alice W. Underwood - Rockville Md</u>  |  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <u>175x</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Multiple abdominal metastasis</u><br>(A) <u>Ovarian Carcinoma</u><br>DUE TO<br>(B) <u>Ovarian Carcinoma</u><br>DUE TO<br>(C) _____ |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <u>7-30-53</u>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>7-18</u> , 19 <u>53</u> to <u>7-30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>53</u> , and that death occurred at <u>12:48</u> m., from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><u>Marjorie H. Hendry</u>  |  | 23B. ADDRESS<br><u>Union Memorial Hospital</u>   |  | 23C. DATE SIGNED<br><u>7-30-53</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24B. DATE<br><u>Aug 1-1953</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn</u>                               |  |
|  |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Balto Md</u>                    |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>31-1953</u>   |  | REGISTRAR'S SIGNATURE<br><u>H. J. Williams</u>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><u>Wm Cook Inc - 1217 St Paul St</u>                |  |

MEDICAL CERTIFICATION

SAINT JOHN'S COLLEGE  
LIBRARY

SAINT JOHN'S COLLEGE  
LIBRARY  
1910



PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

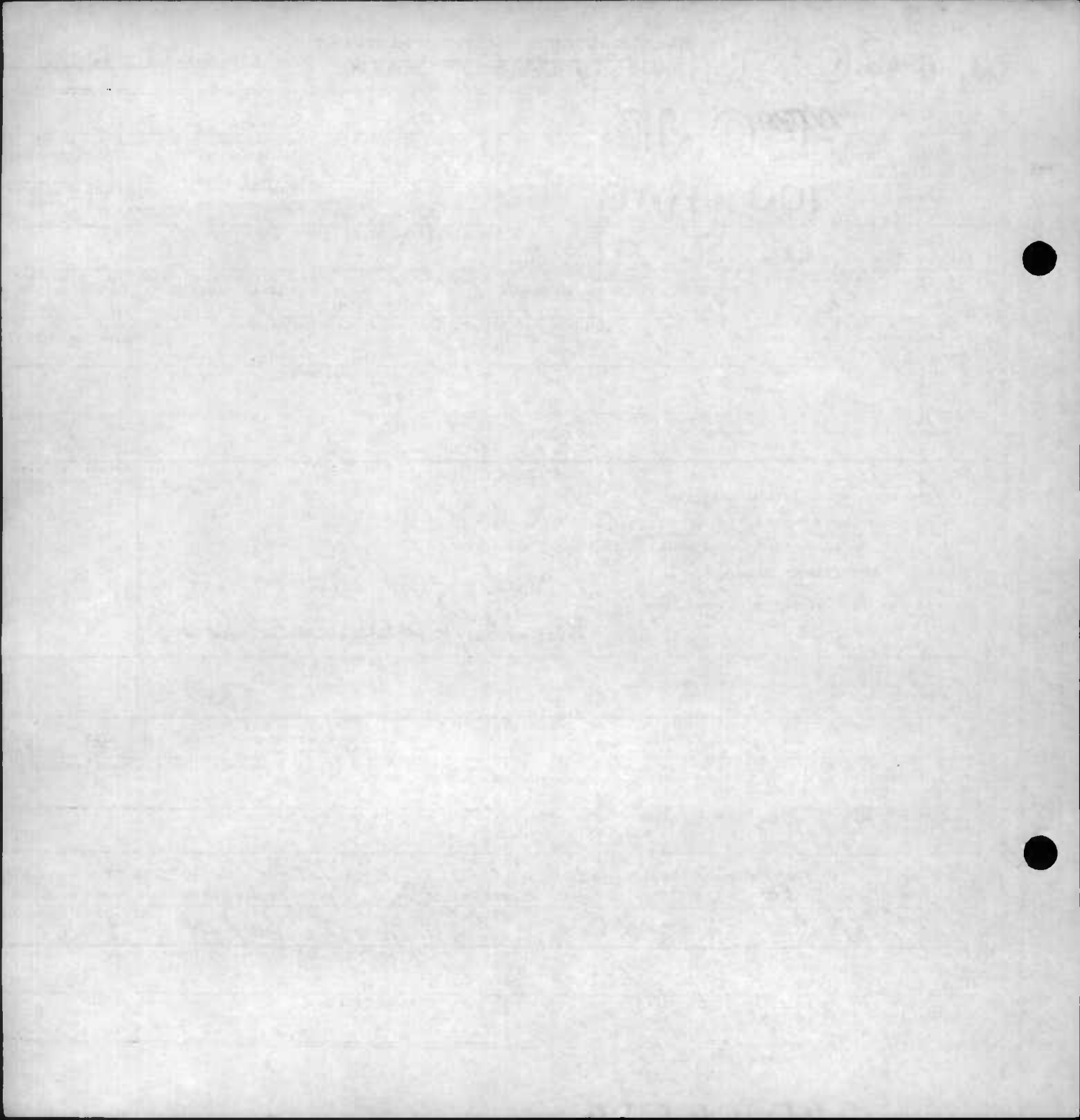
5-310

53 6946

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6946

|  |   |  |  |
|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>NINA M. STAPF</b>  |   | 2. DATE OF DEATH <b>7-30-53</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY HOSPITAL</b>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 20-05</b>                                 |  |
| c. Length of stay in Baltimore<br>Yrs. <b>0</b> Mos. <b>0</b> Days <b>0</b>  |   | D. STREET ADDRESS (If rural, give location)  |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W.</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH <b>May 30-1891</b>                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>72</b>                        |
| 13. FATHER'S NAME <b>—</b>   |   | 14. MOTHER'S MAIDEN NAME <b>—</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO. <b>—</b>   | 17. INFORMANT <b>Warner O Stapf - 347 S Bentall St.</b>          |
| 18. <b>416x I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>UREMIA</b><br>(A) DUE TO                                 |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 da.</b>                 |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <b>CONGESTIVE HEART FAILURE</b><br>(C) <b>Rheumatic or Arteriosclerotic Heart Dis.</b>   |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>7-25</b> , 19 <b>53</b> , to <b>7-30</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-30</b> , 19 <b>53</b> , and that death occurred at <b>7:35 A.M.</b> , from the causes and on the date stated above. |   |  |  |
| 23A. SIGNATURE <b>Wm. W. Loper M.D.</b>  | 23B. ADDRESS <b>Univ. Hospital Balt. Md.</b>  | 23C. DATE SIGNED <b>7-30-53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE <b>Aug 1-1953</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Green Haven</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 31 1953</b>  | REGISTRAR'S SIGNATURE <b>Washington Williams</b>  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Wm Cook, Inc - 1217 St Paul St</b>  |  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6947BIRTH NO. 53 69471. NAME OF DECEASED  
(Type or Print)

JOHN Albert Mackel

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1717 N. Carey Street

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 25, 1892

9. AGE (in years  
last birthday)

61

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Baggage man

10B. KIND OF BUSINESS OR  
INDUSTRY

Pa. R.R.

11. BIRTHPLACE (State or foreign country)

Calvert Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Nathaniel Mackel

14. MOTHER'S MAIDEN NAME

Sarah Y

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Gertrude Mackel  
1717 N. Carey Street

ADDRESS

18. 812.4 and 322.0 CAUSE OF DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Crushing injury of chest

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Acute alcoholism

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

North Avenue &amp; Monroe Street

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 29, 1953 1:05 A.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by automobile

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*R. F. Fisher*23B. CHIEF MEDICAL EXAMINER..... ☒ASSISTANT MEDICAL EXAMINER..... ☐

M.D.

MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

July 29, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

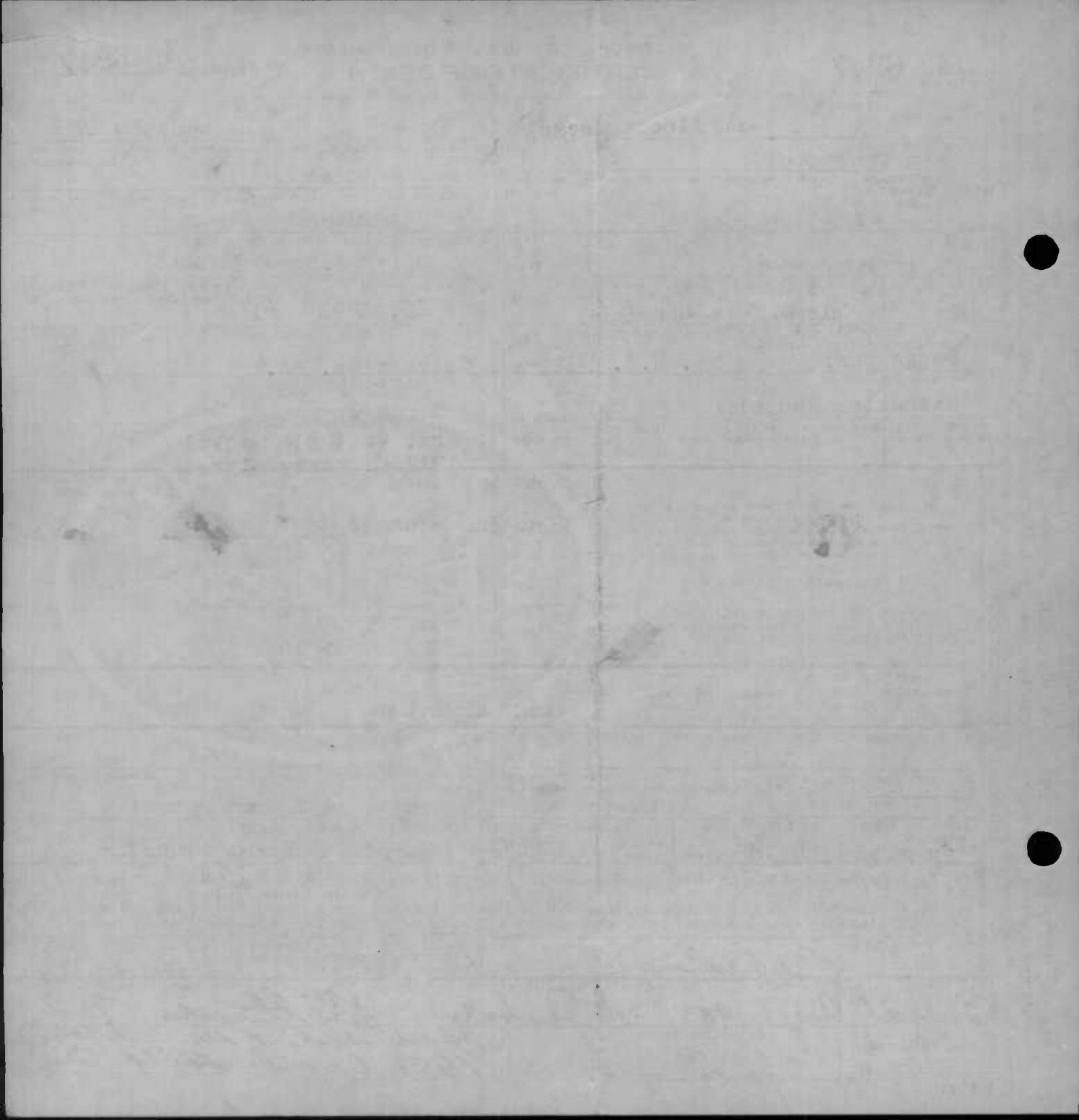
25. FUNERAL DIRECTOR

ADDRESS

VS-151

N-862.20

304 50



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

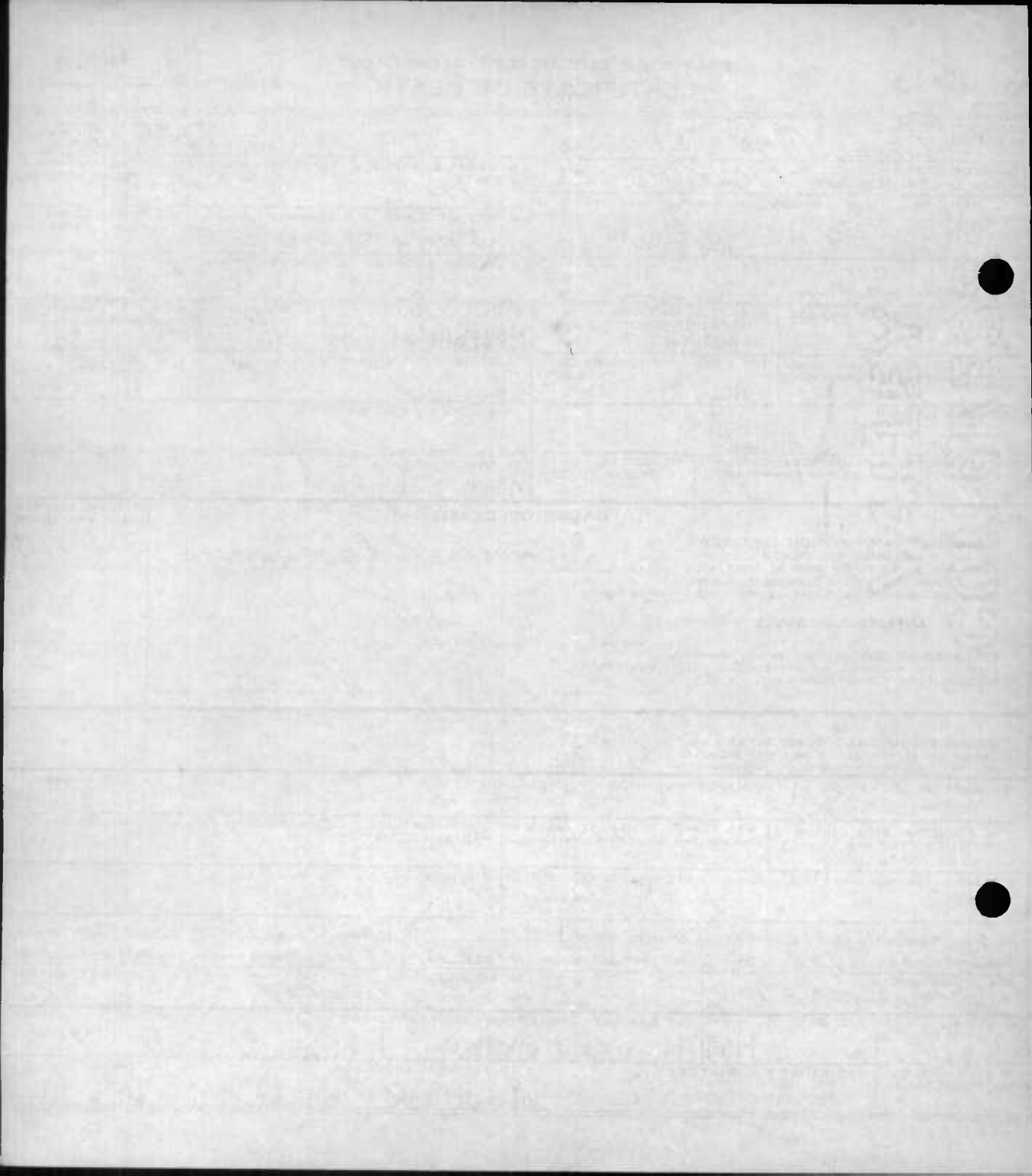
53 6948  
Registered No. \_\_\_\_\_

IRTH NO. \_\_\_\_\_

|  |                              |   |   |  |   |
|--|------------------------------|---|---|--|---|
| NAME OF DECEASED<br>(Type or Print) <b>ETHEL MAY BYERS</b>   |                              |   | 2. DATE OF DEATH<br><b>7/30/53</b>  |  |   |
| PLACE OF DEATH:<br><b>Baltimore City, Maryland</b> <b>BALTIMORE</b>  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MO</b> B. COUNTY <b>9-03</b> |  |   |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>HOME 706 E. 37<sup>TH</sup> ST.</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b>                                  |  |   |
| Length of stay in Baltimore<br><b>33</b> Yrs. <b>33</b> Mos. <b>33</b> Days  |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>706 E 37<sup>TH</sup> ST</b>  |  |   |
| SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/><br>WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> | 8. DATE OF BIRTH<br><b>NOVEMBER 1, 1882</b>   |  | 9. AGE (In years last birthday)<br><b>70</b>  |
| A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)<br><b>HW</b>  |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>ILLINOIS</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| FATHER'S NAME<br><b>JOSEPH BLANCHARD</b>   |                              |   | 14. MOTHER'S MAIDEN NAME  |  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>   |                              | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>JOHN S. BYERS</b>   |  |   |
|  |                              |   | ADDRESS<br><b>ABOVE</b>   |  |   |

|  |  |   |
|--|--|---|
| 18. <b>204.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>LYMPHOID LEUCHEMIA</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Feb-1953</b> |
| (A) DUE TO   |  |   |
| ANTECEDENT CAUSES  |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |   |
| (B) DUE TO   |  |   |
| (C)  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>JAN</b> , 19 <b>53</b> to <b>JULY 30</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7/19</b> , 19 <b>53</b> , and that death occurred at <b>4:35 P.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>W. Earl G. in</b>   |  | 23B. ADDRESS<br><b>4331 HAYFORD RD</b>  |  | 23C. DATE SIGNED<br><b>7/30/53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24B. DATE<br><b>8-1953</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEMORIAL</b>                      |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. CO. MD.</b>   |  | 25. FUNERAL DIRECTOR<br><b>W. JENKINS &amp; SONS CO.</b>  |  | ADDRESS<br><b>4905 YORK RD.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>31 1953</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  |   |  |





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **53 6949**

 BIRTH NO. **53 6949**

|  |                              |  |                                    |
|--|------------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Elijah Howard</b>   |                              | 2. DATE OF DEATH<br><b>July 28, 1953</b>   |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>611 Gold St.</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b> <b>15-01</b>             |                                    |
| c. Length of stay in Baltimore<br>Life Yrs. Mos. Days  |                              | D. STREET ADDRESS (If rural, give location)<br><b>611 Gold St.</b>   |                                    |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>  | 8. DATE OF BIRTH<br><b>8/26/84</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of last year, even if retired)   |                              | 9. AGE (In years last birthday)<br><b>68</b>   |                                    |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                              | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |                                    |
| 13. FATHER'S NAME<br><b>Joshua Howard</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |                                    |
| 16. SOCIAL SECURITY NO.  |                              | 17. INFORMANT ADDRESS<br><b>Elizabeth Howard 611 Gold St. Balto. 17</b>  |                                    |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>443 x I</b><br><b>Cerebro-vascular accident</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>Hypertension, Cardiac Disease</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                              |  |                                    |
| 19A. DATE OF OPERATION<br><b>0</b>   |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                              | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |                                    |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                              | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                                    |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                              | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |                                    |
| 21F. HOW DID INJURY OCCUR?   |                              |  |                                    |
| 22. I hereby certify that I attended the deceased from <b>Feb 20, 1950</b> , to <b>July 28, 1953</b> , that I last saw the deceased alive on <b>July 28, 1953</b> , and that death occurred at <b>9:30 a.m.</b> , from the causes and on the date stated above.  |                              |  |                                    |
| 23A. SIGNATURE<br><b>Washington Jones</b> M. D.  |                              | 23B. ADDRESS<br><b>1300 N. Fremont</b>   |                                    |
| 23C. DATE SIGNED<br><b>7/30/53</b>   |                              |  |                                    |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 24B. DATE<br><b>8/1/53</b>   |                                    |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Marley Neck</b>   |                              | 24D. LOCATION (City, town, or county) (State)<br><b>A. A. Co. Md.</b>  |                                    |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Huntington Williams</b>   |                              | 25. FUNERAL DIRECTOR<br><b>Geo. G. Nelson 1303 Presstman St.</b>   |                                    |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-300

53 6950

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6950

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mrs. Fern Fethe</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 30, 1953</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Yes</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bon Secours Hospital</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                     |  |   |
| c. Length of stay in Baltimore <b>Life-time</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>5003 Frederick Ave, Balto-29-Md.</b>   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>4/4/1894</b>  | 9. AGE (in years last birthday)<br><b>59</b> | 10. Under 1 Year<br>Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RET. - SALESLADY</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>  |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |
| 13. FATHER'S NAME<br><b>Benjamin F. Kerr</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Agnes Mayes</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  |   | 16. SOCIAL SECURITY NO. _____  |  |   |
| 17. INFORMANT<br><b>Mrs. Fethe - 5003 Fred. Ave.</b>   |                                  |   | ADDRESS _____  |  |   |

|  |  |  |   |
|--|--|--|---|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Uremia</b>                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6</b>  |
| DUE TO   |  |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Lower Nephron Nephrosis</b>   |  |  | <b>7</b>  |
| DUE TO   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Paralytic ileus -</b>  |  |  | <b>9</b>  |
| 19A. DATE OF OPERATION<br><b>7/20/53</b>   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 19B. MAJOR FINDINGS OF OPERATION<br><b>Myoma Uteri</b>   |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><input type="checkbox"/> |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>            | 21F. HOW DID INJURY OCCUR?<br><input type="checkbox"/>   |   |
| 22. I hereby certify that I attended the deceased from <b>7/20/53</b> , 19 <b>53</b> , to <b>7/30/53</b> , that I last saw the deceased alive on <b>7/30/53</b> and that death occurred at <b>m.</b> from the causes and on the date stated above. |  |  |   |
| 23A. SIGNATURE<br><b>John E. Carroll</b>   |  | 23B. ADDRESS<br><b>Bon Secours Hospital</b>  | 23C. DATE SIGNED<br><b>7/30/53</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7-30-53</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cems.</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn Md.</b>                |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE  | 25. FUNERAL DIRECTOR<br><b>George D. Farley - Catonsville, Md.</b>                                   |   |

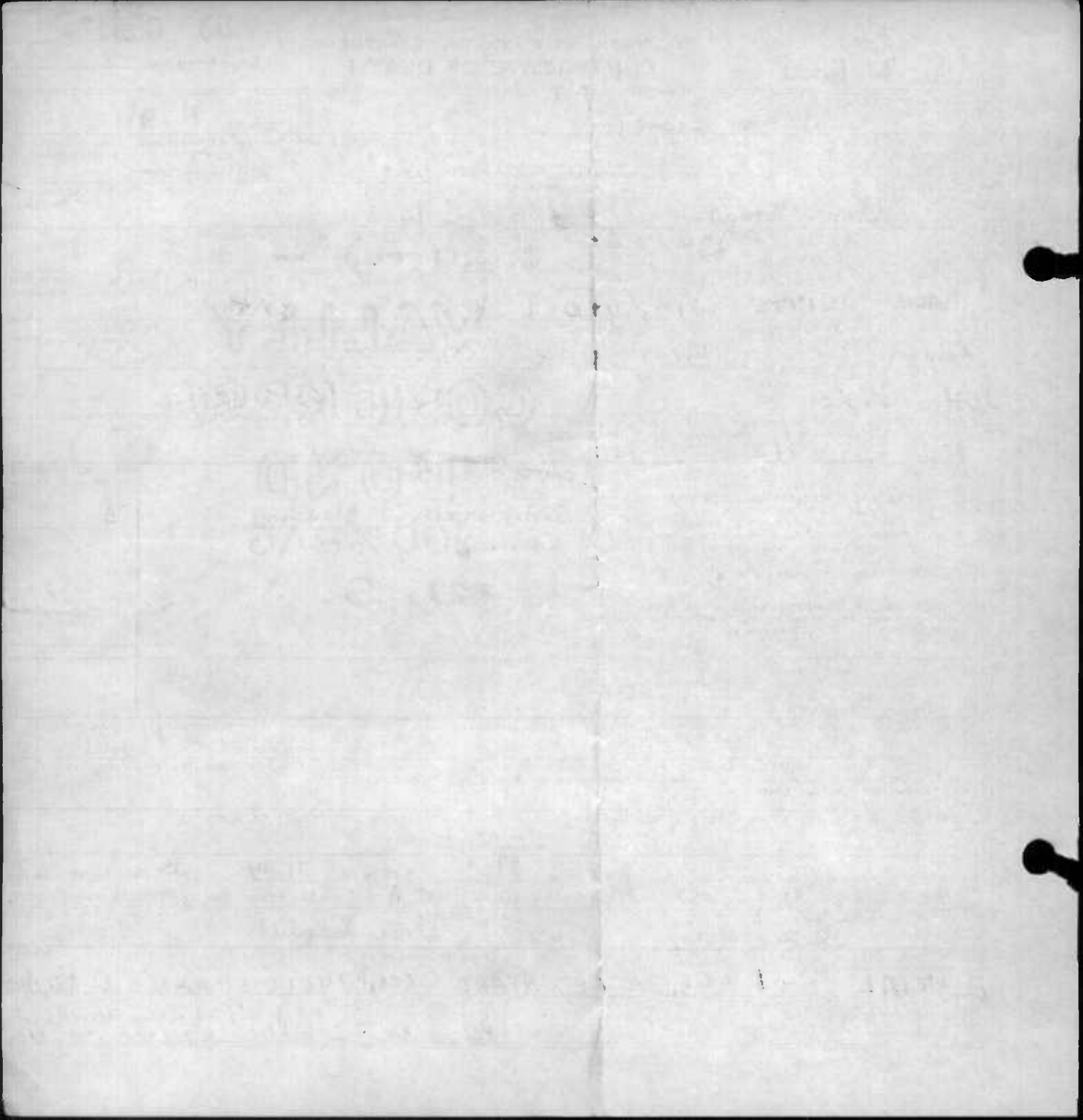
4906C



PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| Z-140<br>53 6951   |                               | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |   | 53 6951<br>Registered No.  |                               |
|--|-------------------------------|--|---|--|-------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>John Zipfel</b>  |                               |  | 2. DATE OF DEATH <b>7/29/53</b>   |  |                               |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                               |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> |  |                               |
| b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Univ. Hospital</b>  |                               |  | c. CITY OR TOWN <b>City</b>   |  |                               |
| c. Length of stay in Baltimore <b>ABOUT 60</b> Yrs. Mos. Days  |                               |  | d. STREET ADDRESS (If rural, give location) <b>3217 Fleet St #24</b>  |  |                               |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify) <b>WIDOWED</b>  | 8. DATE OF BIRTH <b>11-19-65</b>  | 9. AGE (In years last birthday) <b>87</b>  | 10. Under 1 Year Months: Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>BUTCHER</b>  |  |                               |
| 11. BIRTHPLACE (State or foreign country) <b>Germany</b>   |                               |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                               |
| 13. FATHER'S NAME <b>JOHN Zipfel</b>   |                               |  | 14. MOTHER'S MAIDEN NAME <b>Neder, KATHERINE</b>  |  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>  |   | 17. INFORMANT <b>Leo Zipfel</b> ADDRESS <b>S</b>   |                               |
| 18. <b>578X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Gastro-intestinal bleeding</b><br>DUE TO <b>Cause?</b>    |                               |  | INTERVAL BETWEEN ONSET AND DEATH <b>3</b>   |  |                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                      |                               |  |   |  |                               |
| 19a. DATE OF OPERATION <b>0</b>  |                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II                  |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                               | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |   | 21c. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                     |                               |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |                               |
| 22. I hereby certify that I attended the deceased from <b>7/27</b> , 19 <b>52</b> , to <b>7/29</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/28</b> , 19 <b>53</b> , and that death occurred at <b>1:15 A.m.</b> , from the causes and on the date stated above. |                               |  |   |  |                               |
| 23a. SIGNATURE <b>Alfred Venevsky</b>  |                               | 23b. ADDRESS <b>Univ. Hospital</b>   |   | 23c. DATE SIGNED <b>7/29/53</b>  |                               |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 24b. DATE <b>8-1-53</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>                                  |                               |
| 24d. LOCATION (City, town, or county) <b>7401 GERMAN HILL RD, MD.</b>  |                               | 24e. LOCATION (State) <b>MD.</b>   |   |  |                               |
| DATE RECEIVED BY LOCAL REGISTRAR <b>Huntington Williams, M.D.</b>  |                               | REGISTRAR'S SIGNATURE  |   | 25. FUNERAL DIRECTOR <b>Charles S. Zeiler</b> ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b> |                               |





K-523  
53 6952BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6952  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Knockett Jr.

2. DATE  
OF  
DEATH

7-30-53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give  
township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1608 Lorman St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

ed

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 26, 1885

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none employed

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Craven N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abraham Knockett

14. MOTHER'S MAIDEN NAME

Charity

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Geo. Knockett Jr. 1024 Buntlaw St

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebro-vascular Accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular Disease

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from July 30, 1953, to July 30, 1953, that I last saw the  
deceased alive on July 30, 1953, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

George R. Seymour M.D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

July 31, 1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Aug 3, 1953

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cem Balto. Md

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

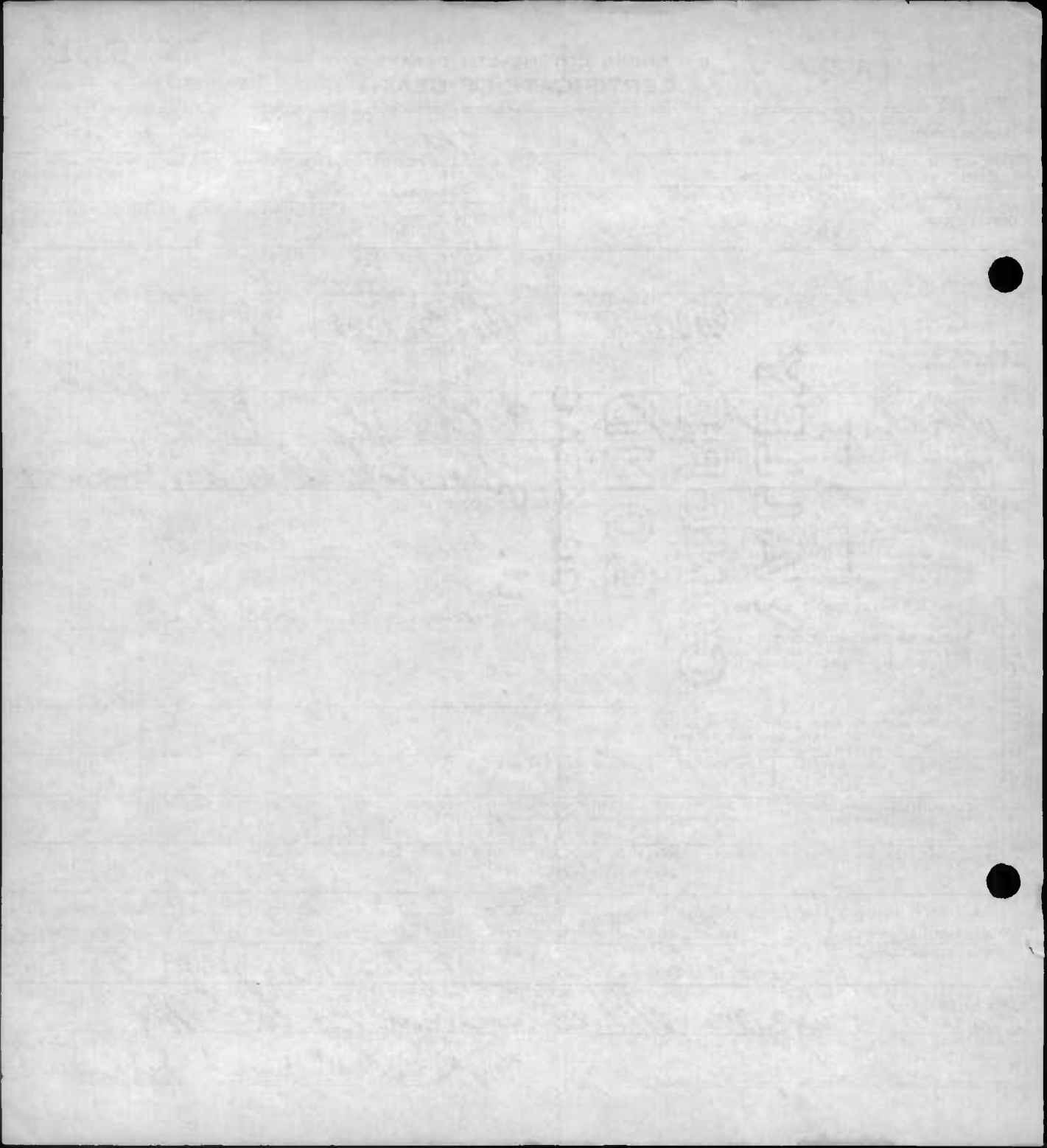
William H. Williams M.D.

25. FUNERAL DIRECTOR

Mrs Kate R Williams

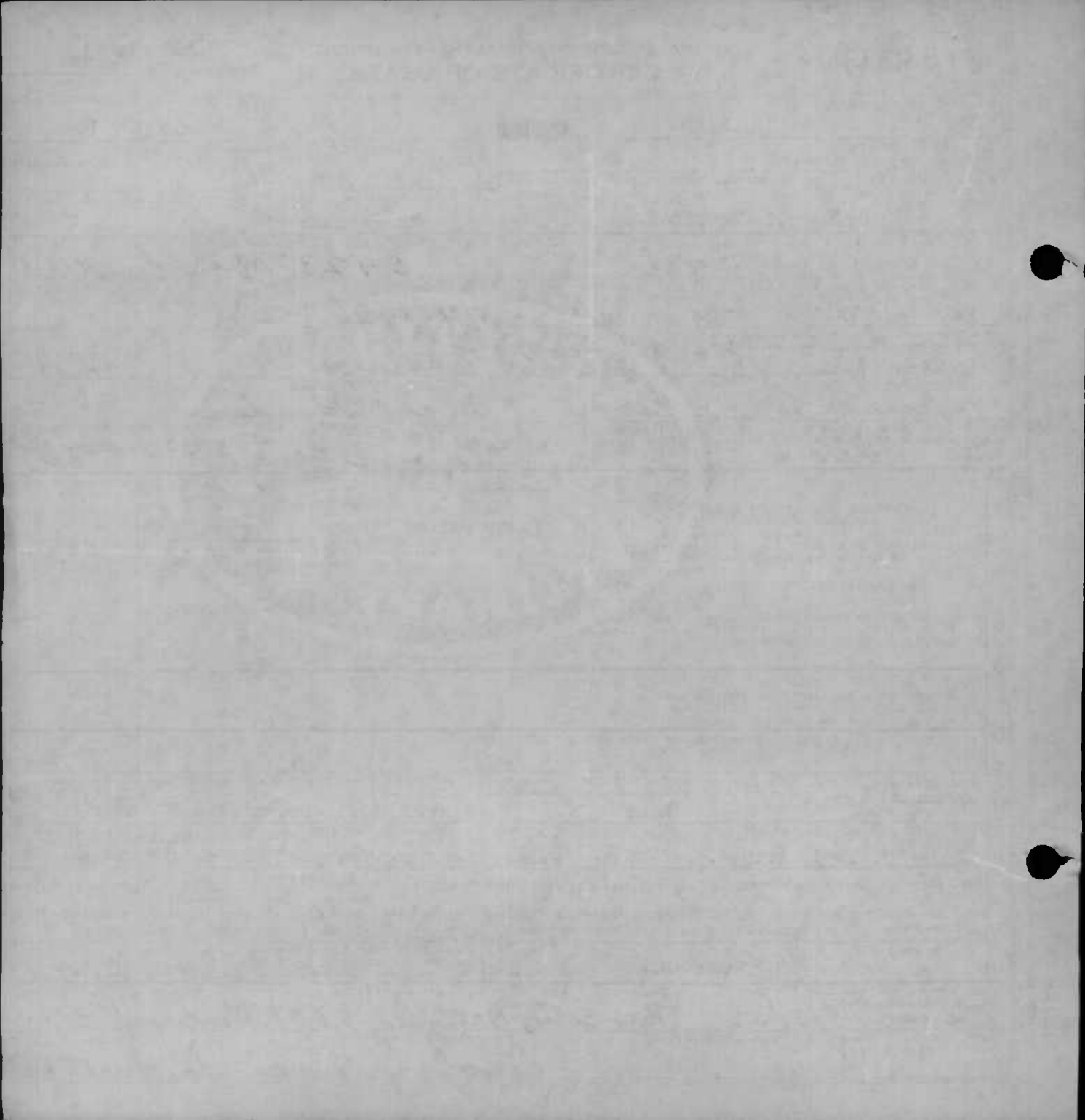
ADDRESS

322 N Schroeder St



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6853  
Registered No.

|  |   |   |                              |   |   |
|--|---|---|------------------------------|---|---|
| BIRTH NO. 53 53 8953   |   | 1. NAME OF DECEASED<br>(Type or Print) RICHARD GREISZ   |                              | 2. DATE OF DEATH July 30, 1953  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland        |                              |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>University Hospital   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore Catonsville             |                              |   |   |
| C. Length of stay in Baltimore Life  |   | D. STREET ADDRESS (If rural, give location)<br>5423 Masfield Rd.  |                              |   |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White               | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married  | 8. DATE OF BIRTH<br>3/7/1926 | 9. AGE (In years last birthday)<br>27   | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Wireman   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Elec Co  |                              | 11. BIRTHPLACE (State or foreign country)<br>Baltimore                                    |   |
| 13. FATHER'S NAME<br>Harry M. Greisz   |   | 14. MOTHER'S MAIDEN NAME<br>Mary Harden   |                              | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br>yes World War II   |   | 16. SOCIAL SECURITY NO.<br>-  |                              | 17. INFORMANT<br>Mrs Joan H. Greisz   |   |
| 18. L914.8   |   | CAUSE OF DEATH  |                              | INTERVAL BETWEEN ONSET AND DEATH  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |   | (A) Electrocution   |                              |   |   |
| ANTECEDENT CAUSES  |   | (B)   |                              |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | DUE TO  |                              |   |   |
| (C)  |   |   |                              |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |   |                              |   |   |
| 19A. DATE OF OPERATION   |   | 19B. MAJOR FINDINGS OF OPERATION  |                              | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Road                  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Ellicott City |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>July 30, 1953 1:15 P. m.  |   | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                              | 21F. HOW DID INJURY OCCUR? Contacted high tension wires and was electrocuted              |   |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |   |   |                              |   |   |
| 23A. SIGNATURE<br>R. Fisher  |   | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....             |                              | 23C. DATE SIGNED<br>July 31, 1953   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  | 24B. DATE<br>8/3/53                     | 24C. NAME OF CEMETERY OR CREMATORY<br>New Balto Natl Cem  |                              | 24D. LOCATION (City, town, or county) (State)<br>5501 Frederick Ave                       |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>Aug 31 1953  | REGISTRAR'S SIGNATURE<br>H. H. Williams | 25. FUNERAL DIRECTOR<br>John J. Cowan & Son   |                              | ADDRESS<br>5405 E   |   |



|  |  |   |  |  |   |
|--|--|---|--|--|---|
| <div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">13-630</div> <div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">533 6954</div>  |  | <div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">CERTIFICATE OF DEATH</div> |  | <div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">53 6954</div> <div style="font-weight: bold; margin-bottom: 5px;">Registered No. _____</div> |   |
| RTH NO. _____<br>NAME OF DECEASED (Type or Print) <i>Ida Berry</i>   |  | 2. DATE OF DEATH <i>July 30-1953</i>  |  |  |   |
| PLACE OF DEATH: <i>Baltimore City, Maryland 120 Valley St</i>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE _____ B. COUNTY _____   |  |  |   |
| FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-02</i>  |  |  |   |
| Length of stay in Baltimore <i>4 months</i><br>SEX <i>female</i> Yrs. Mos. Days _____  |  | D. STREET ADDRESS (If rural, give location)<br><i>3019 Guilford Ave</i>   |  |  |   |
| 6. COLOR OR RACE <i>colored</i>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   |  | 8. DATE OF BIRTH <i>1880</i>   |   |
| 9. AGE (In years last birthday) <i>73</i>  |  | 10. KIND OF BUSINESS OR INDUSTRY <i>Kelly Berry</i>   |  | 11. BIRTHPLACE (State or foreign country) <i>Oxford Md</i>   |   |
| 12. CITIZEN OF WHAT COUNTRY? _____   |  | 13. FATHER'S NAME <i>James Nixon</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Caroline Nixon</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) _____  |  | 16. SOCIAL SECURITY NO. _____   |  | 17. INFORMANT ADDRESS <i>Little Sisters of the Poor</i>  |   |
| 18. <i>331X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES _____  |  | CAUSE OF DEATH<br>(A) <i>Cerebral Hemorrhage</i><br>DUE TO _____<br>(B) <i>Arterio Sclerosis</i><br>DUE TO _____<br>(C) _____   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>3 yrs</i>  |   |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____  |  |   |  |  |   |
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION _____  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____  |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21F. HOW DID INJURY OCCUR? _____   |   |
| 22. I hereby certify that I attended the deceased from <i>July 9-</i> , 19 <i>53</i> , to <i>July 30</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>July 29</i> , 19 <i>53</i> , and that death occurred at <i>4 P.M.</i> , from the causes and on the date stated above. |  |   |  |  |   |
| 23A. SIGNATURE <i>E. G. Hall M.D.</i>  |  | 23B. ADDRESS <i>1631 E. North Ave</i>   |  | 23C. DATE SIGNED <i>July 30-53</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 24B. DATE <i>Aug 1, 1953</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>  |   |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>   |  | 25. FUNERAL DIRECTOR ADDRESS <i>Rela Wredefeld 900 E. Biddle St</i>   |  |  |   |

CERTIFICATE OF DEATH

|   |  |
|---|--|
| <p>1. Name of deceased: _____</p>       |  |
| <p>2. Sex: _____</p>                    |  |
| <p>3. Age: _____</p>                    |  |
| <p>4. Date of death: _____</p>          |  |
| <p>5. Place of death: _____</p>         |  |
| <p>6. Cause of death: _____</p>         |  |
| <p>7. Signature of physician: _____</p> |  |
| <p>8. Signature of registrar: _____</p> |  |



0-530

53 6955

APPROVED BY MEDICAL EXAMINER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53 6955

Registered No.

IRTH NO.

NAME OF DECEASED  
(Last name or Print)

Smith, Maude O.

2. DATE

OF  
DEATH

July 30, 1953

PLACE OF DEATH:

Baltimore City, Maryland

FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3807 Egerton Road

SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

Yrs.  
Mos.  
Days

Length of stay in Baltimore

life

9. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

Home duties

10b. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

Aug. 27, 1869

9. AGE (In years last birthday)

83

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore  
Maryland

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME

Charles Olive

14. MOTHER'S MAIDEN NAME

Cora Thomas

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Howard Haenmiller 3807 Egerton Road

18. E903.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subtrochanteric fracture, left femur

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY

Joseph A. Jachimczyk M. D.

CHIEF OR ASST. MEDICAL EXAMINER

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

generalized  
Cerebral arteriosclerosis and arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Own home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3807 Egerton Road

15/10

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 26, 1953

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell to the floor  
Fell at home

22. I hereby certify that I attended the deceased from May 26, 1953, to July 30, 1953, that I last saw the deceased alive on July 30, 1953, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

23. SIGNATURE

St. Joseph's Hospital

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

July 30, 1953

A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 1, 1953

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville,

Md.

DATE RECEIVED BY CAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1900 Eutaw Place



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6956

Registered No.

BIRTH NO.

|   |                                    |   |   |  |  |
|---|------------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SARA SARA BARNES</b>  |                                    |   | 2. DATE OF DEATH <b>July 29, 1953</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>  |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Joseph's Hospital</b>   |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                  |  |  |
| c. Length of stay in Baltimore <b>30 yrs</b>  |                                    |   | D. STREET ADDRESS (If rural, give location)<br><b>1534 Aisquith Street</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b> | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)<br><b>53</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>      |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>             | 11. BIRTHPLACE (State or foreign country)<br><b>St. Maries Co., Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>John Greenwell</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Greenwell</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                                    | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>Laura Zinker</b>  |  | ADDRESS                                      |

18. **443X I**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Hypertensive cardiovascular disease with myocardial insufficiency**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
(C) \_\_\_\_\_II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
AT WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
M.D. MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
**July 29, 1953**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

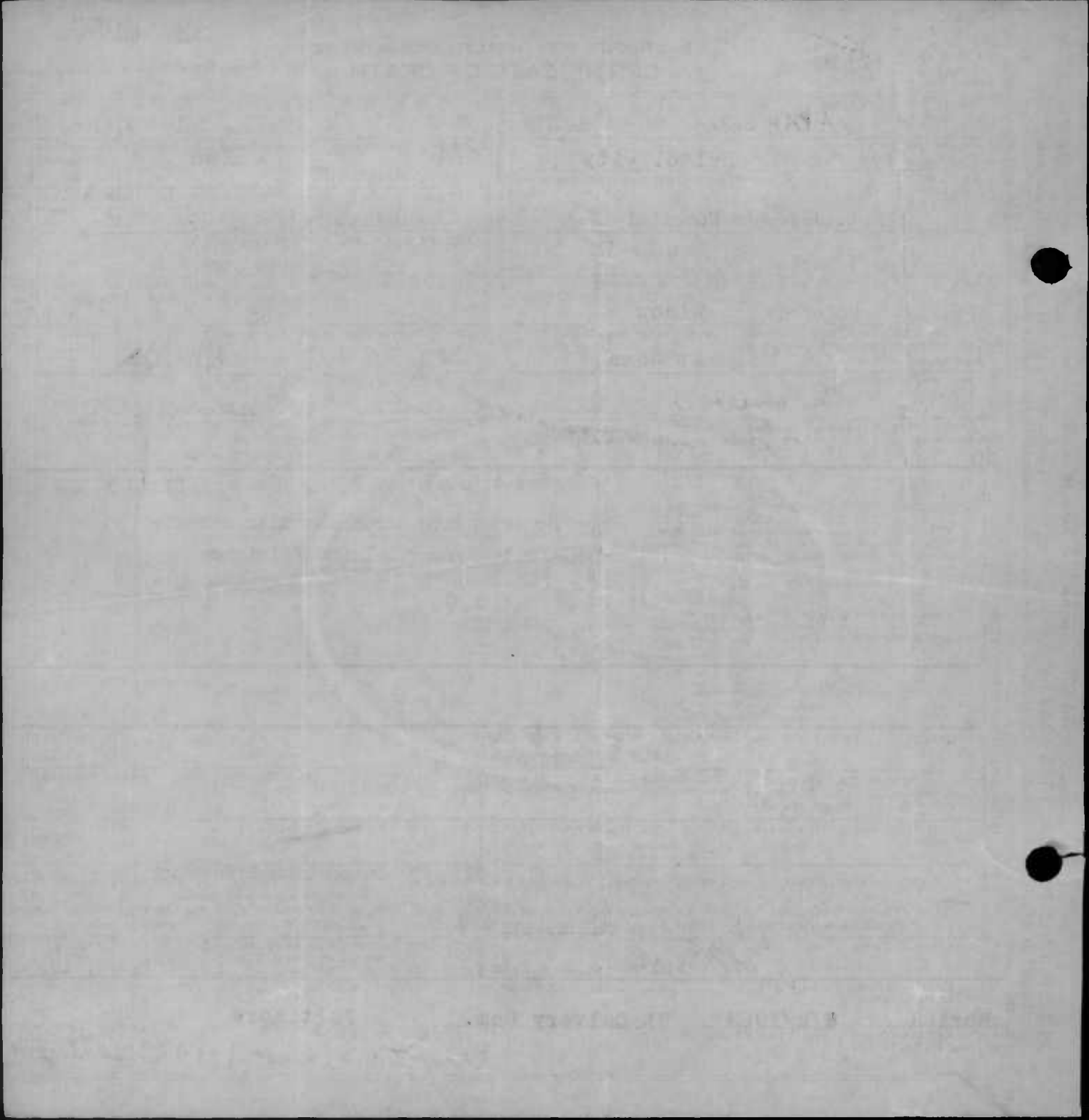
**Burial****8/2/1953****Mt Calvary Cem.****Baltimore**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| Baltimore City Health Department<br>CERTIFICATE OF DEATH   |                                  |   |                                    | 53 6957<br>Registered No.   |  |
|--|----------------------------------|---|------------------------------------|---|--|
| BIRTH NO. 53 6957  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <u>Anna Beck ANNIE BECK</u>  |                                    | 2. DATE OF DEATH <u>July 30, 1953</u>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u><br>B. COUNTY |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 2-03</u> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>JOHNS HOPKINS HOSPITAL</u>   |                                  | D. STREET ADDRESS (If rural, give location)<br><u>507 S. Washington St.</u>   |                                    | E. LENGTH OF STAY IN BALTIMORE<br><u>LIFE</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Single</u>  | 8. DATE OF BIRTH<br><u>3-28-81</u> | 9. AGE (In years last birthday)<br><u>72</u>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>POTASH ROOM</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>POTASH ROOM</u>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>TIN DECORATING CO</u>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>BALTIMORE, MD</u>                                     |  |
| 13. FATHER'S NAME<br><u>JOHN BECK.</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>KATHERINE TINE</u>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>24-03-2442</u>  |                                    | 17. INFORMANT ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>  |  |
| 18. <u>420.1 and 260X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>CAUSE OF DEATH</u> |                                  | (A) <u>Myocardial infarction</u><br>DUE TO  |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  | (B) <u>Generalized arteriosclerosis</u><br>DUE TO   |                                    | <u>20 yrs</u>   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  | <u>Diabetes mellitus</u>  |                                    |   |  |
| 19A. DATE OF OPERATION<br><u>7-27-53</u>   |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                  |                                    | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                              |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |                                    | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>7-27-53</u> , to <u>7-30-53</u> , that I last saw the deceased alive on <u>7-30-53</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.       |                                  |   |                                    |   |  |
| 23A. SIGNATURE<br><u>Henry N. Wagner Jr.</u>   |                                  | 23B. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |                                    | 23C. DATE SIGNED<br><u>7/30/53</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 24B. DATE<br><u>AUG 3 1953</u>  |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>OAK LAWN CEM.</u>  |  |
| 24D. LOCATION (City, town, or county)<br><u>EASTERN AVE RD MD</u>  |                                  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><u>101 31 1953</u>   |                                    | 24F. REGISTRAR'S SIGNATURE<br><u>Huntington Williams, M.D.</u>  |  |
| 24G. FUNERAL DIRECTOR<br><u>1800 E LOMBARD ST</u>  |                                  | 24H. ADDRESS<br><u>6903A</u>  |                                    |   |  |

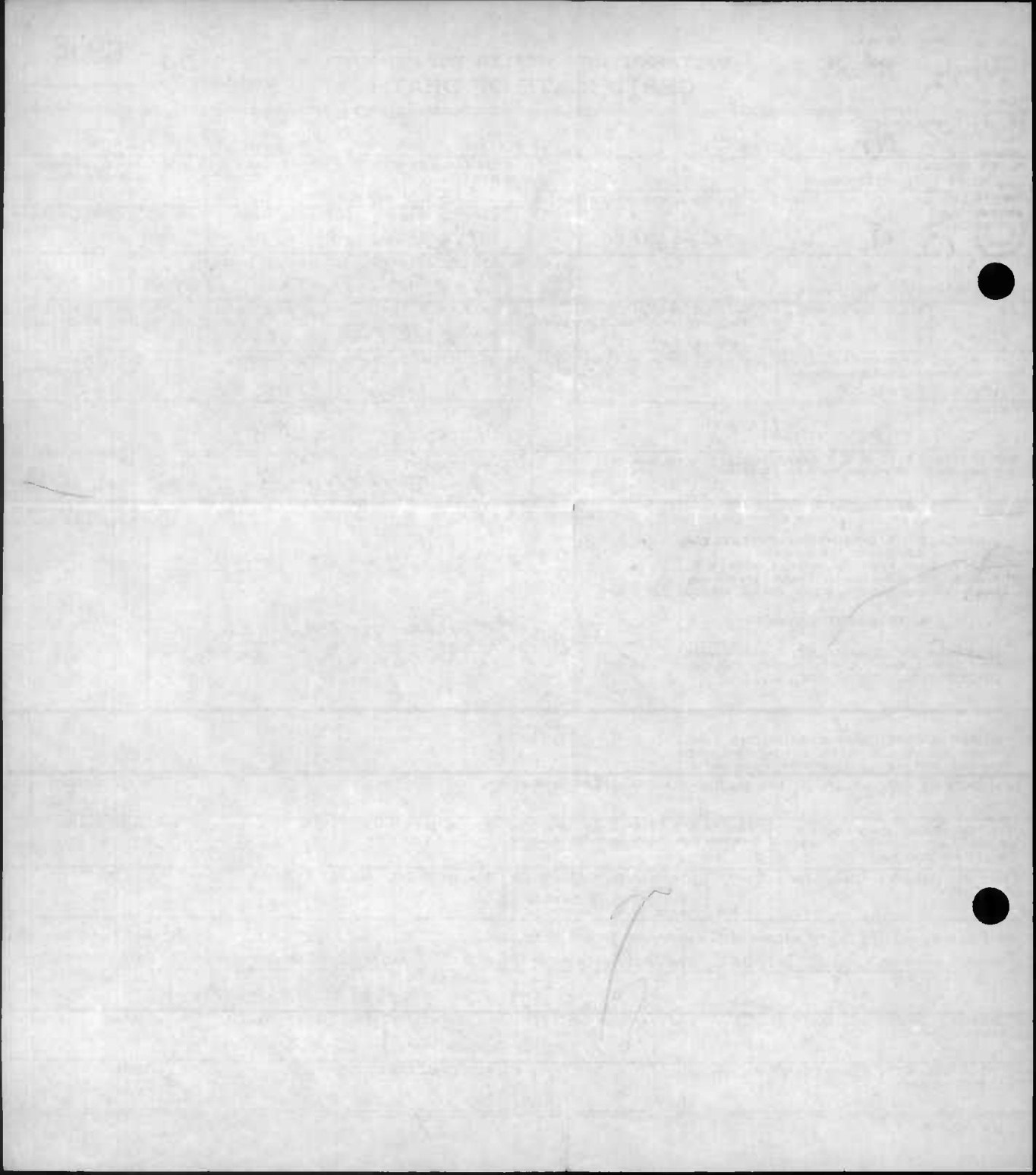




0-254  
53 6958BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6958  
Registered No.

RTH NO.

|  |                              |  |  |
|--|------------------------------|--|--|
| NAME OF DECEASED<br>(Type or Print) <i>Clara Sillery O'Donnell</i>   |                              | 2. DATE OF DEATH <i>7-30-53</i>  |  |
| PLACE OF DEATH:<br><i>Baltimore City, Maryland</i>   |                              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY |  |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>Union Memorial Hospital</i>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore -18 12-06</i>                     |  |
| Length of stay in Baltimore <i>78</i> Yrs Mos. Days  |                              | D. STREET ADDRESS (If rural, give location)<br><i>Hopkin's Apts Apt 311</i>  |  |
| SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  | 8. DATE OF BIRTH<br><i>1-4-1875</i>              |
| A. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><i>Housewife</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>—</i>  | 9. AGE (In years last birthday)<br><i>78</i>     |
| FATHER'S NAME<br><i>Charles Sillery</i>  |                              | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md</i>   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>       |
| DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>—</i>  |                              | 16. SOCIAL SECURITY NO.<br><i>—</i>  | 14. MOTHER'S MAIDEN NAME<br><i>Lydia Buckley</i> |
| 18. <i>443X1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral hemorrhage.</i>                                       |                              | CAUSE OF DEATH<br>(A) <i>Cerebral hemorrhage.</i><br>DUE TO  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Hypertensive Arteriosclerotic Cardio-vascular Disease</i>   |                              | (B) <i>Hypertensive Arteriosclerotic Cardio-vascular Disease</i><br>DUE TO<br>(C)  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                              |  |  |
| 19A. DATE OF OPERATION<br><i>—</i>   |                              | 19B. MAJOR FINDINGS OF OPERATION<br><i>—</i>   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  |                              | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                              |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                              | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  |
| 21F. HOW DID INJURY OCCUR?   |                              |  |  |
| 22. I hereby certify that I attended the deceased from <i>July 30</i> 19 <i>53</i> , to <i>July 30</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>July 30</i> , 19 <i>53</i> , and that death occurred at <i>2:10 P</i> m., from the causes and on the date stated above. |                              |  |  |
| 23A. SIGNATURE<br><i>Alfred E. Osman, Jr.</i>  |                              | 23B. ADDRESS<br><i>3219 N. Calvert St. Balto.</i>  |  |
| 23C. DATE SIGNED<br><i>7-30-53</i>   |                              |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                              | 24B. DATE<br><i>8/3/53</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral</i>   |                              | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                              | 25. FUNERAL DIRECTOR<br><i>Huntington Williams, Mt. Washington</i>   |  |
| REGISTRAR'S SIGNATURE  |                              | ADDRESS<br><i>501 E. 22<sup>nd</sup> St.</i>   |  |



53 6959

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 53 6959  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert. Bell.

2. DATE  
OF  
DEATH

7/30/53.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland.

B. COUNTY

Fred.

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)HOSPITAL OR  
INSTITUTION

University Hospital.

C. CITY OR TOWN

Walkerville.

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

P.O. #1

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1888

9. AGE (In years  
last birthday)

65

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Farmer.

10B. KIND OF BUSINESS OR  
INDUSTRY

farming.

11. BIRTHPLACE (State or foreign country)

Maryland.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Cyrus Bell

14. MOTHER'S MAIDEN NAME

Theresa Eason  
Amor Esworthy Walkerville, Fred.15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Amor. Esworthy. Walkerville Md

18. 393.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) meningitis.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) cerebellar. abscess. - left

DUE TO

(C) chronic. mastoiditis. - left

about. 30 days

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pneumonitis; cachexia.

19A. DATE OF OPERATION

7-24-53

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED (cerebellar abscess. - left  
chronic. suppurative mastoiditis)IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19 1953 to July 30 1953, that I last saw the  
deceased alive on July 29 1953, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert Longo Cadmus M.D.

23B. ADDRESS

Annermit Hospital

23C. DATE SIGNED

7/30/53.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

8/2/53

24C. NAME OF CEMETERY OR CREMATORY

Union Chapel

24D. LOCATION (City, town, or county)

Mt. Liberty town Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

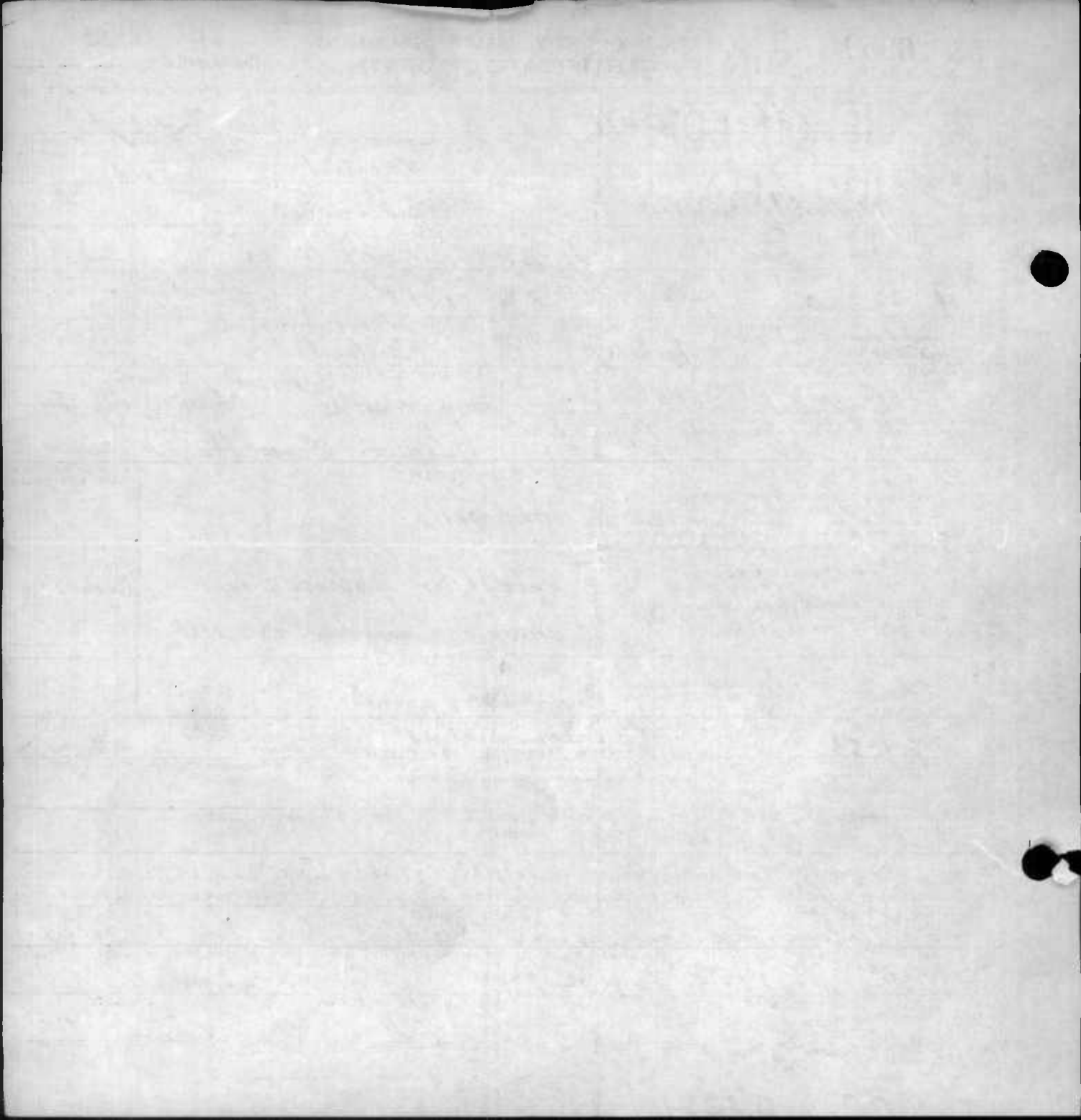
REGISTRAR'S SIGNATURE

H. H. Williams, M.D.

25. FUNERAL DIRECTOR

J. P. Etchison, Son - Frederick Md.

ADDRESS



4-160  
53 6960BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

334X

53 6960  
Registered No. ....

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 6000 Bellona Avenue
- (c) Hospital or institution: Edgewood Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 4 1/2 yrs

3 (a) FULL NAME ' Mrs. Hattie M. Avery

3 (b) If veteran, name war no 3 (c) Social Security Account No. none

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Arba A. Avery 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1859

8. AGE: Years 93 Months Days If less than one day hr. min.

9. Birthplace Rhode Island (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name John Pharnes

13. Birthplace

14. Maiden Name Harriet Pharnes

15. Birthplace

16 (a) Informant Mrs. Lucy Eger, daughter

(b) Address 6116 Moyer Avenue #14

17 (a) Burial (b) Date thereof Aug. 3, 1953 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pine Grove Cemetery Location Whitinsville, Massachusetts

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road #14

19 (a) 2-1-1052 (b) (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
- (c) City or town Baltimore 27-05 (If outside city or town limits, write RURAL and give town)
- (d) Street No. 6116 Moyer Avenue (If rural, give location)
- (e) Citizen of foreign country? No (Yes or No) If yes, name country.

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1953, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1950, to July 16 1953, and that I last saw her alive on July 16 1953.

Immediate cause of death

arterio sclerosis, 14 years  
(cerebral) 14 years  
Dementia 14 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide. none
- (b) Date of occurrence none at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? none While at work?

(Specify type of place)

(e) Means of injury D. From Street

23. Signature M. D. Park Ave. Date signed 7/31/53

Duration

14 years

14 years

14 years

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



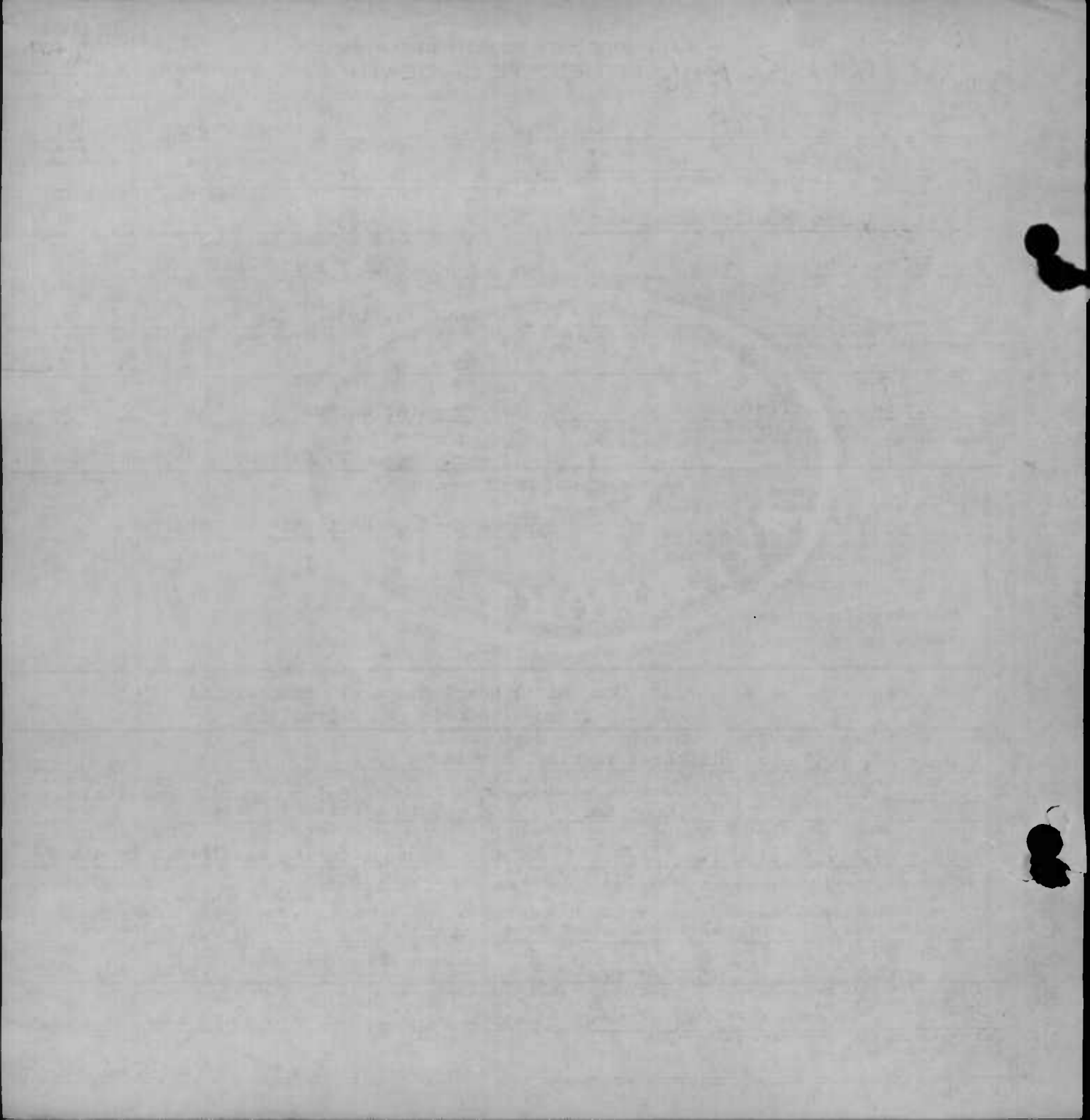
## BALTIMORE CITY HEALTH DEPARTMENT

53 6961

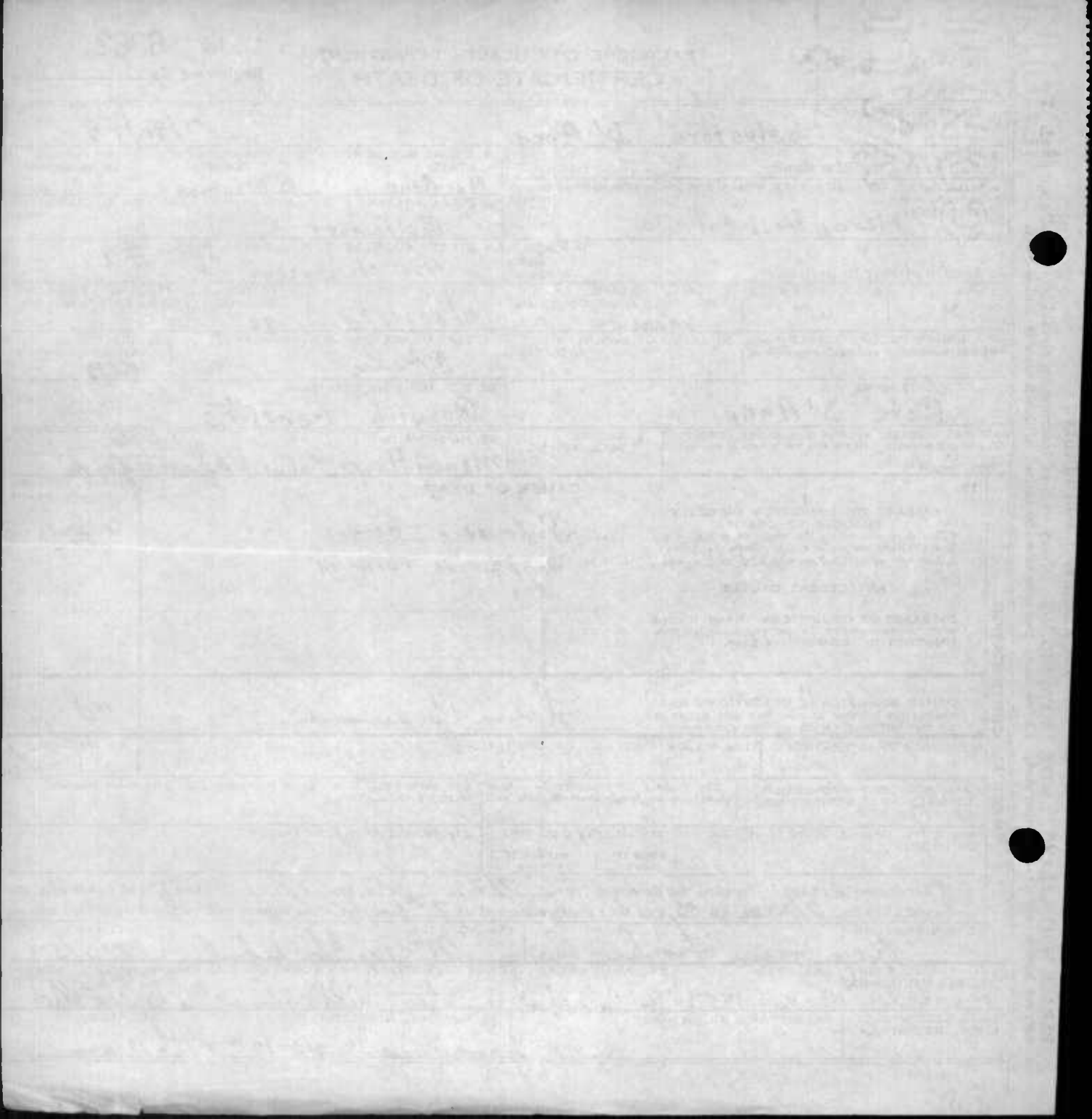
## CERTIFICATE OF DEATH

Registered No.

|  |                           |   |  |   |  |
|--|---------------------------|---|--|---|--|
| BIRTH NO. 53 6961 51-1976  |                           | 1. NAME OF DECEASED<br>(Type or Print) GARY CLIFFORD  |  | 2. DATE OF DEATH July 29, 1953  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Union Memorial Hospital   |                           |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Towson                     |   |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           |   | D. STREET ADDRESS (If rural, give location)<br>8306 Bon Air Road   |   |  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single   | 8. DATE OF BIRTH<br>Aug. 25, 1951  | 9. AGE (In years last birthday)<br>1  | 10. Under 1 Year Months Days             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                           | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A. |
| 13. FATHER'S NAME<br>Eugene W. Clifford  |                           |   | 14. MOTHER'S MAIDEN NAME<br>Margaret Dorsch  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br>Mr. Eugene W. Clifford, 8306 Bon Air Rd.  |   |  |
| 18. 560.0 and E 954.7 CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) Syncope during anesthesia by ether<br>DUE TO<br>ANTECEDENT CAUSES<br>(B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT<br>II Congenital heart disease: Endocardial fibro-elastosis and valvulitis |                           |   |  |   | INTERVAL BETWEEN ONSET AND DEATH         |
| 19A. DATE OF OPERATION<br>July 29, 1953  |                           | 19B. MAJOR FINDINGS OF OPERATION<br>Bilateral inguinal hernia   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>Hospital             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Union Memorial Hospital<br>33rd & Calvert Streets |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>July 29, 1953 1:30 P. m.  |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br>Syncope during anesthesia by ether  |  |
| 22. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .   |                           |   |  |   |  |
| 23A. SIGNATURE<br>Joseph A. Jarlins  |                           | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....                  |  | 23C. DATE SIGNED<br>July 30, 1953   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 24B. DATE<br>August 1-1953  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore City Cemetery   |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.   |                           | 24E. FUNERAL DIRECTOR<br>Leonard J. Ruck  |  | 24F. ADDRESS<br>5305 Highland Rd.   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |                           | REGISTRAR'S SIGNATURE   |  | 25. FUNERAL DIRECTOR ADDRESS  |  |







M-610  
53 6963

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6963  
Registered No.

BIRTH NO.

|   |                                  |  |   |   |   |
|---|----------------------------------|--|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary C. Murphy (Mamie Murphy)</b>   |                                  |  |   | 2. DATE OF DEATH<br><b>7/29/53</b>  |   |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |                                  |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>City</b> |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>1302 Aisquith Street</b>  |                                  |  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |   |
| 6. Length of stay in Baltimore <b>Life</b>  |                                  |  |   | D. STREET ADDRESS (If rural, give location)<br><b>1302 Aisquith Street</b>  |   |
| 7. SEX<br><b>Female</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>                                      | 10. DATE OF BIRTH<br><b>Sept. 26th., 1882</b>                       |   | 11. AGE (in years last birthday)<br><b>70</b>                                       |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  |  | 13. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                 |   | 14. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>             |
| 15. FATHER'S NAME<br><b>John Herman Hoffmeyer</b>   |                                  |  | 16. MOTHER'S MAIDEN NAME<br><b>Mary Emma Burke</b>                  |   |   |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |                                  |  | 18. SOCIAL SECURITY NO.<br><b>None</b>                              |   |   |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>None</b>   |                                  |  | 20. INFORMANT ADDRESS<br><b>William G. Murphy-1302 Aisquith St.</b> |   |   |
| 18. <b>260X</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ARTERIOSCLEROTIC C.V.D. DISEASE</b><br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 YEARS</b> |                                  |  |   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>ARTERIOSCLEROTIC, Generalized</b><br>DUE TO<br><b>DIABETES MELLITUS</b><br>DUE TO<br><b>10 YEARS</b>   |                                  |  |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>CEREBRAL HEMIPARESIS</b><br><b>5 YEARS</b>  |                                  |  |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>6/26/46</b> , 19 <b>46</b> , to <b>7/29/53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/29/53</b> , 19 <b>53</b> , and that death occurred at <b>9:30 p.m.</b> , from the causes and on the date stated above.   |                                  |  |   |   |   |
| 23A. SIGNATURE<br><b>Becky B. Muns, M.D.</b>  |                                  | 23B. ADDRESS<br><b>448 N. Luzerne Ave</b>  |   | 23C. DATE SIGNED<br><b>7/31/53</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>Aug. 11 1953</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |   |
| 24D. LOCATION (City, town, or county)<br><b>Edmondson Ave. Balto: Md.</b>   |                                  | 24E. STATE<br><b>(State)</b>   |   |   |   |
| 25. DATE RECEIVED BY LOCAL REGISTRAR<br><b>Aug 21 1953</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>  |   | 25. FUNERAL DIRECTOR ADDRESS<br><b>George J. Ruth, Inc. - 1735 Harford Avenue</b>   |   |
| VS 150<br><b>George J. Ruth Inc. Hgt</b>  |                                  |  |   |   |   |

DECLARATION OF DEATH

STATE OF TEXAS

COUNTY OF DALLAS

JOHN L. BROWN

DECEASED

WILLIAM L. BROWN, JR.



K-640

53 6964  
BIRTH NO. 83 17057

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

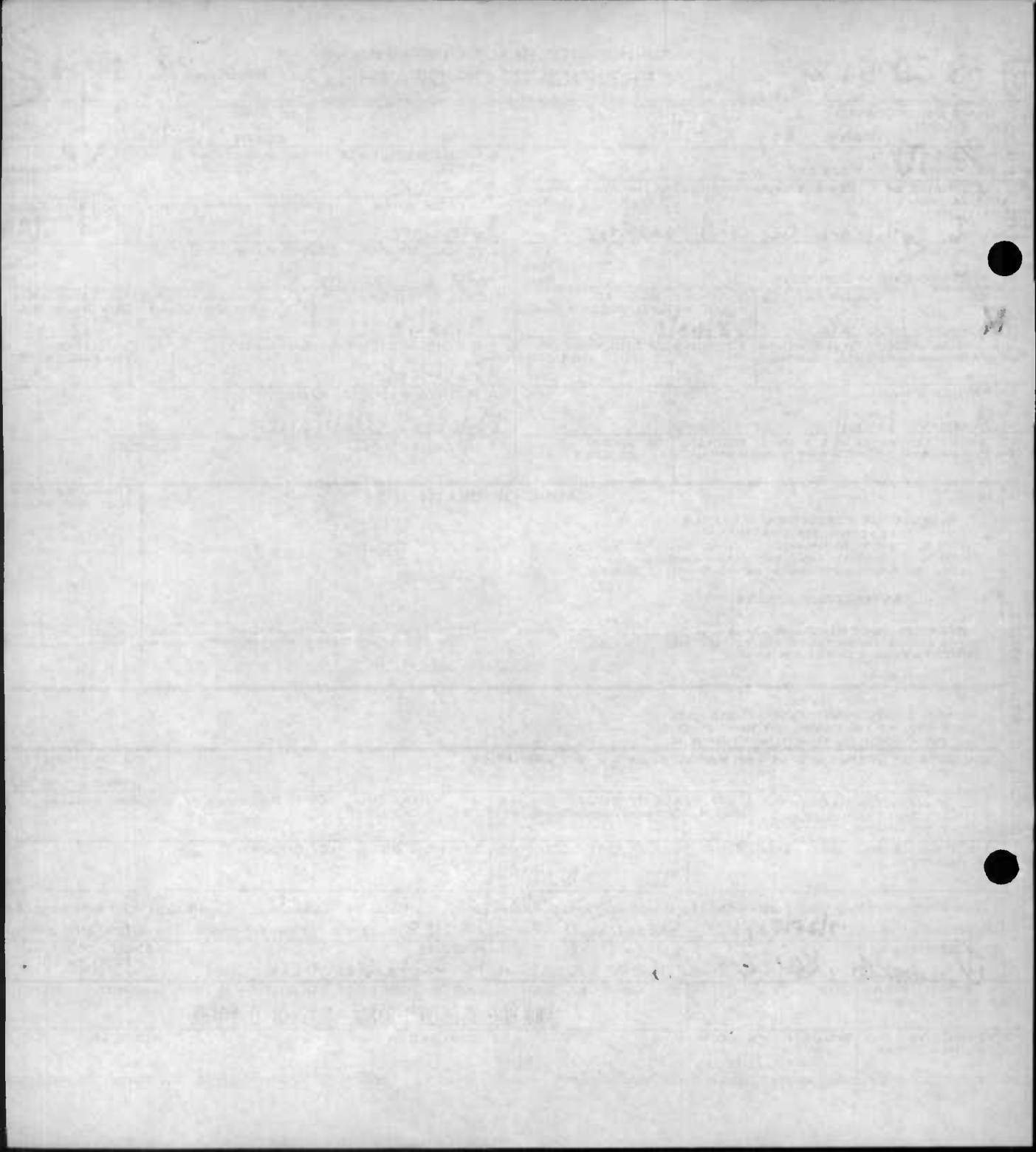
53 6964  
Registered No.

|   |                                  |  |   |  |  |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy Krell</b>  |                                  |  | 2. DATE OF DEATH <b>7/25/53</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland ✓   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>24-04</b> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>South Baltimore General Hospital</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |  |
| C. Length of stay in Baltimore  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>220 E. Varney St.</b>   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>7/25/53</b>  |  | 9. AGE (In years last birthday)<br><b>2</b> Months <b>3</b> Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                     |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?                                     |
| 13. FATHER'S NAME<br><b>Edwin Krell</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Dolores Williams.</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                        |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS   |  |  |

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 18. <b>752X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH                           |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | (A) <b>Hydrocephalus + Spina-Bifida.</b> |  |                                  |
|  | (B) <b>8-13-</b>                         |  |                                  |
|  | (C) <b>Unknown.</b>                      |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>7/25/53</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>7/25/53</b> , 19__, to <b>7/25/53</b> , 19__, that I last saw the deceased alive on <b>7/25/53</b> , 19__, and that death occurred at <b>8:15 P. m.</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>D. J. Bowers</b>   |  | 23B. ADDRESS<br><b>South Balto. Gen. Hosp.</b>   |  | 23C. DATE SIGNED<br><b>7/27/53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
|   |  |  |  | 24D. LOCATION (City, town, or county) (State)                                       |  |

|                                  |  |  |  |   |  |
|----------------------------------|--|--|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Jr.</b> |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Huntington Williams, Jr.</b> |  |
|----------------------------------|--|--|--|---|--|



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6965

BIRTH NO. 53 6965 53-16322

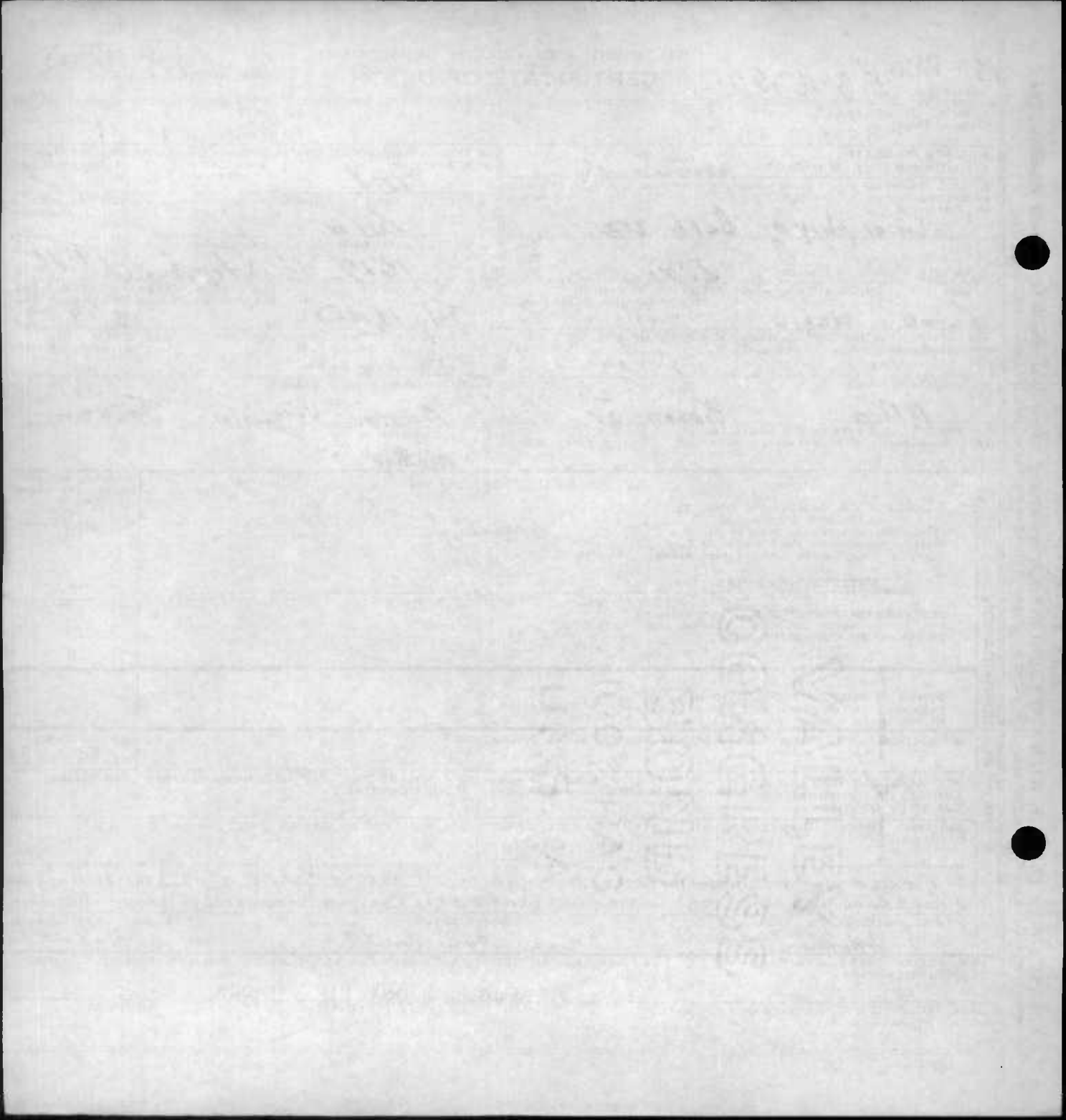
|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY EASON</b>  |                                  |  | 2. DATE OF DEATH<br><b>July 22/53</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore City</b>   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b><br>B. COUNTY <b>md</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Sinai Hosp of Balh. Inc.</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltd. 15-06</b>                                |  |   |
| c. Length of stay in Baltimore <b>Life</b><br>Yrs. Mos. Days  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>1614 St. Stephen St. #16</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>July 19, 1953</b>   |  | 9. AGE (in years last birthday)<br><b>3 9 3</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>              |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                 | 11. BIRTH PLACE (State or foreign country)<br><b>Baltimore</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>Allen Eason, Jr.</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Edna Virginia Jackson</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>(If yes, give war or dates of service)</b>      |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>Mother</b>   |  |   |

|   |  |  |
|---|--|--|
| 18. <b>726x I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br>(A) <b>Prematurity</b><br>DUE TO<br>(B) <b>1-13 3/4</b><br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days 9 hrs.</b> |
|---|--|--|

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 19</b> , 19 <b>53</b> , to <b>July 22</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 22</b> , 19 <b>53</b> , and that death occurred at <b>2:40 p. m.</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>P. Schaffer</b>   |  | 23B. ADDRESS<br><b>M. D. Sinai Hospital</b>  |  | 23C. DATE SIGNED<br><b>July 28-53</b>   |  |

|   |           |   |  |
|---|-----------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)             | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY                          | 24D. LOCATION (City, town, or county) (State)      |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>AUG 1 1953</b> |           | REGISTRAR'S SIGNATURE<br><b>John Hopkins Medical School</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>Jul 30 1953</b> |



MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

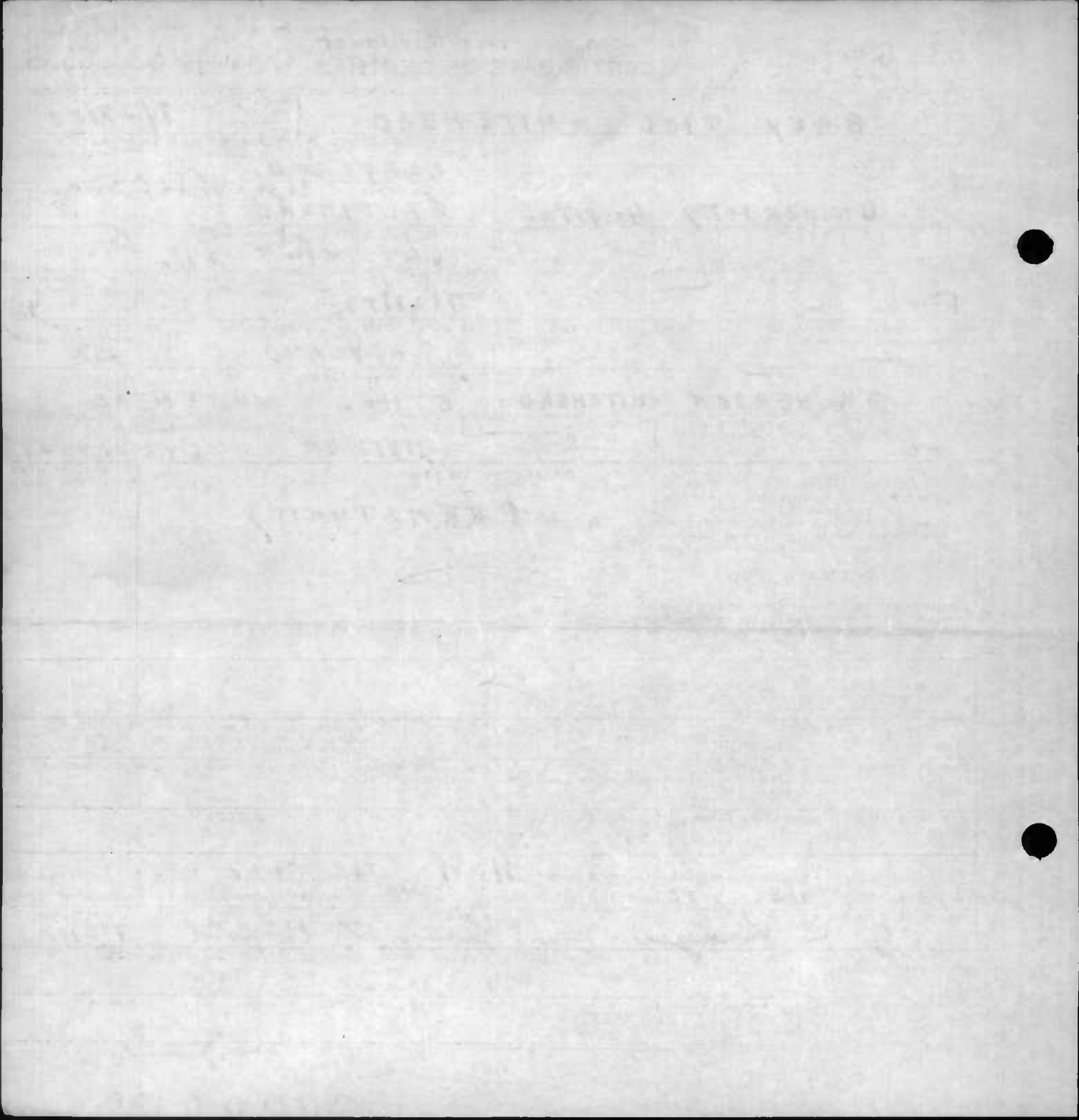
W-330  
53 6966  
BIRTH NO. 53-20843

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

CITY DISPOSAL  
Registered No. 53 6966

|   |                              |   |  |  |   |
|---|------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY GIRL WHITEHEAD</b>   |                              |   | 2. DATE OF DEATH<br><b>7/27/53</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>UNIVERSITY HOSPITAL</b>    |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 4-02</b>                          |  |   |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>648 VINE ST.</b>   |  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>C</b> | 7. <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><b>7/27/53</b>   | 9. AGE (In years last birthday)<br><b>45</b> | 10. Under 1 Year Months Days<br><b>45</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                           |                              |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                              |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |
| 13. FATHER'S NAME<br><b>GRANERSON WHITEHEAD</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>ETHEL WHITEHEAD</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                              |   | 16. SOCIAL SECURITY NO.<br><b>—</b>  |  |   |
| 17. INFORMANT<br><b>MOTHER</b>  |                              |   | ADDRESS<br><b>648 VINE ST</b>  |  |   |

|  |  |   |                                  |   |  |
|--|--|---|----------------------------------|---|--|
| 18. <b>776 x 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>PREMATURITY</b><br>DUE TO                                  |  |   | INTERVAL BETWEEN ONSET AND DEATH |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C)  |  |   |                                  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |                                  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                  | 20. AUTOPSY?<br>IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |                                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>7/27/53</b> , 19 <b>53</b> , to <b>7/27</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7/27</b> , 19 <b>53</b> , and that death occurred at <b>6:00 P. M.</b> , from the causes and on the date stated above. |  |   |                                  |   |  |
| 23A. SIGNATURE<br><b>G. H. Krager</b>  |  | 23B. ADDRESS<br><b>University Hospital</b>  |                                  | 23C. DATE SIGNED<br><b>7/27/53</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>JOHN HOPKINS MEDICAL SCHOOL</b>  |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>AUG 1 1953</b>  |                                  | 24F. REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Jr.</b>   |  |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR  |  | 24H. REGISTRAR'S SIGNATURE  |                                  | 24I. FUNERAL DIRECTOR'S ADDRESS<br><b>Huntington Williams, Jr.</b>  |  |





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-324

53 6967  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6967  
Registered No.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE RALPH WEITZEL</b>  |                                  |   |  | 2. DATE OF DEATH<br><b>July 31, 1953</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>28-41</b> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>3948 Dolfield Ave.</b> |                                  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                       |  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>3948 Dolfield Ave.</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>Aug. 29, 1893</b>               |  | 9. AGE (In years, last birthday)<br><b>59</b>              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auditor</b>                           |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b> |
| 13. FATHER'S NAME<br><b>George B. Weitzel</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Clarice Upp</b>         |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>World War No. 1</b>                 |  | 17. INFORMANT ADDRESS<br><b>Mrs. Hilda A. Weitzel - 3948 Dolfield Av</b>   |  |

|   |  |   |
|---|--|---|
| 18. <b>331X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral hemorrhage</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arterio sclerosis</b>  |  | <b>2 yrs.</b>                                     |
| (A) DUE TO  |  |   |
| (B) DUE TO  |  |   |
| (C) DUE TO  |  |   |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |   |  |  |
|---|---|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **7-29-1953**, to **7-31-1953**, that I last saw the deceased alive on **7-31-1953** and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

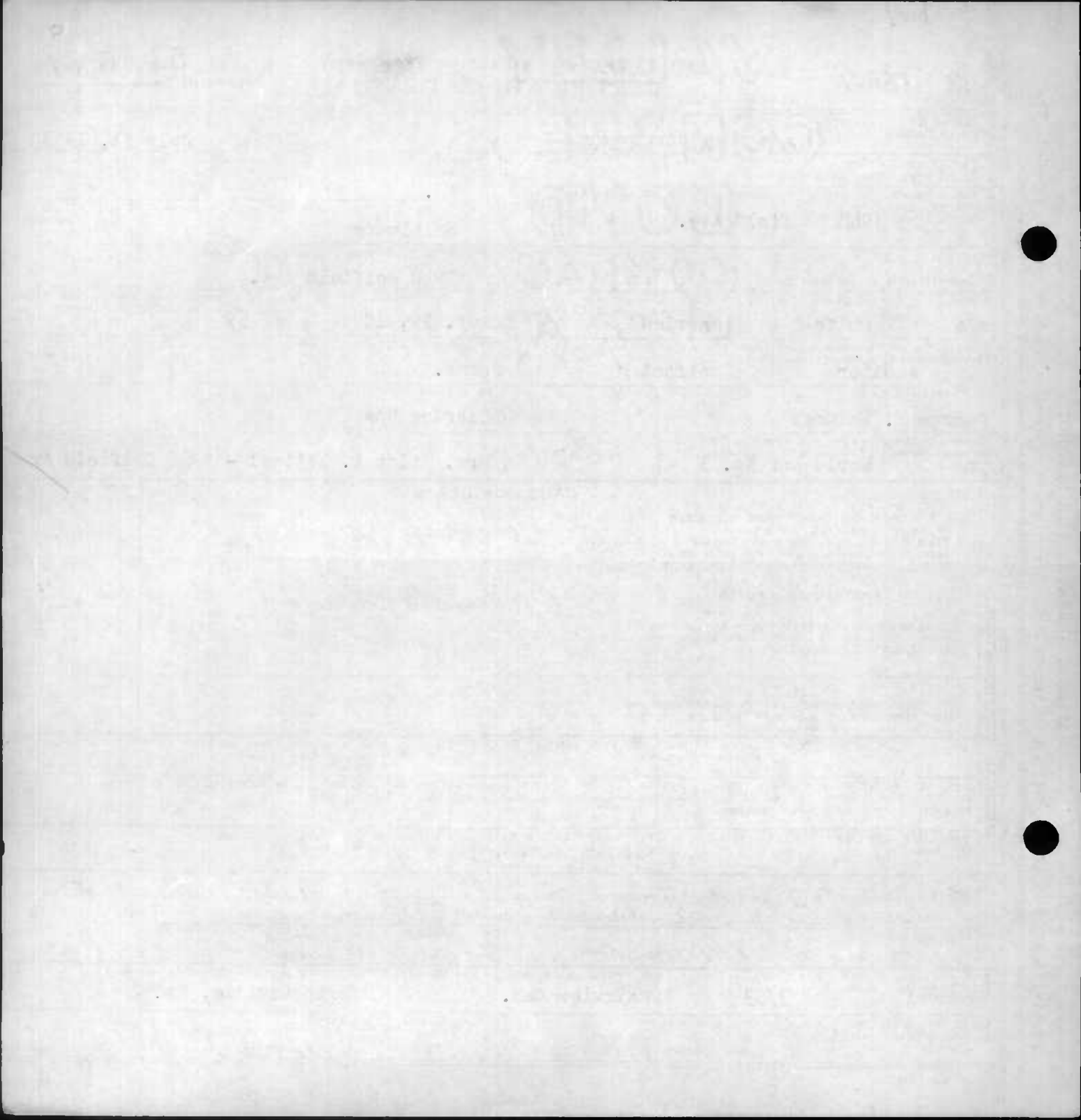
|   |   |                                   |
|---|---|-----------------------------------|
| 23A. SIGNATURE<br><b>Howard H. Warren</b> | 23B. ADDRESS<br><b>2604 Garrison Bldg</b> | 23C. DATE SIGNED<br><b>8-1-53</b> |
|---|---|-----------------------------------|

|   |                            |  |   |
|---|----------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24B. DATE<br><b>8/3/53</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Wrightsville, Pa.</b> |
|---|----------------------------|--|---|

|   |   |   |                                |
|---|---|---|--------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>61</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Wm. J. Vickener &amp; Sons</b> | ADDRESS<br><b>Balto 17 Md.</b> |
|---|---|---|--------------------------------|

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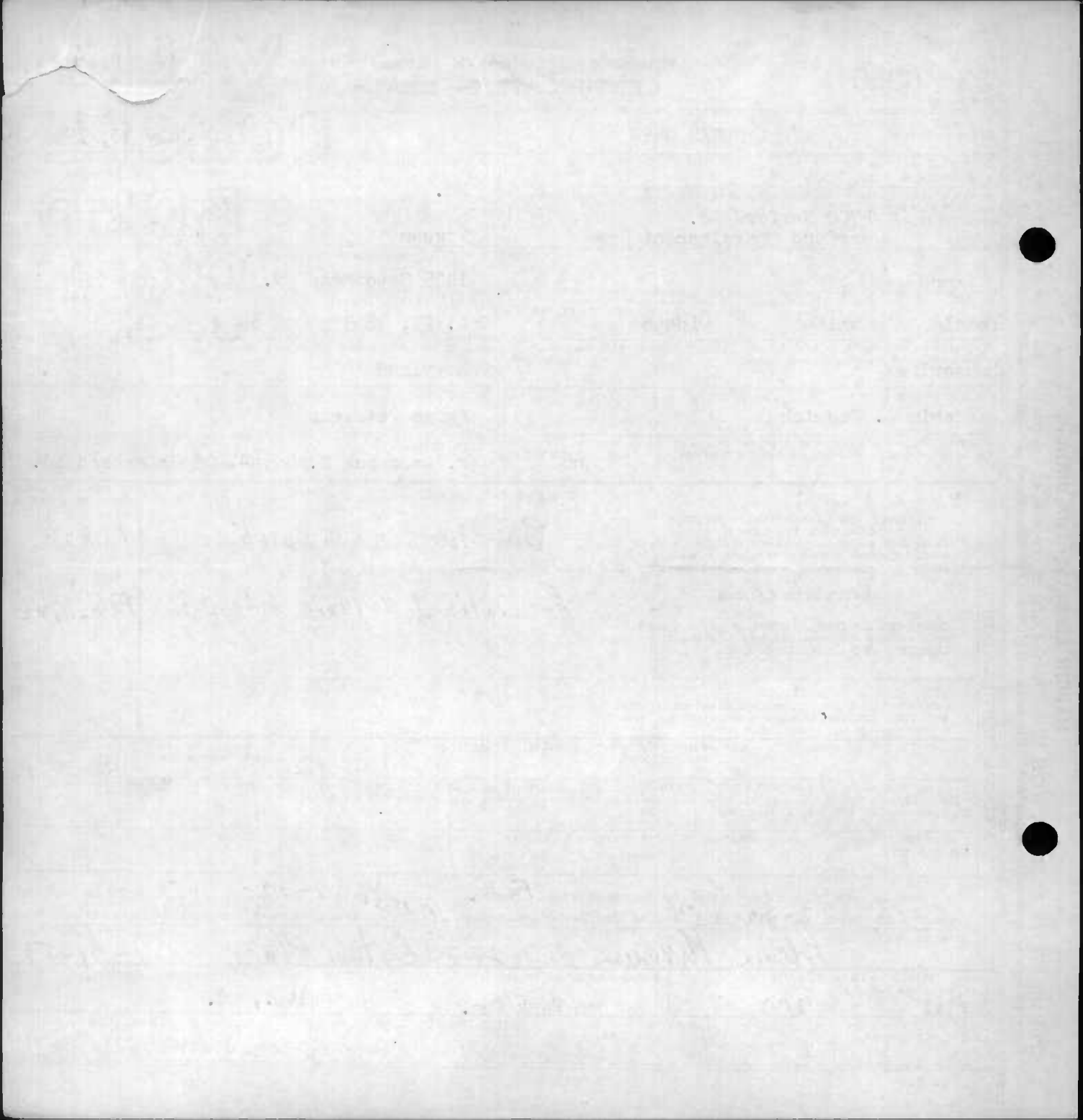
G-500

53 6968

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6968  
Registered No.

BIRTH NO.

|   |  |  |   |  |  |  |  |                                       |  |  |
|---|--|--|---|--|--|--|--|---------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  |  | SUSAN GWYN  |  |  | 2. DATE OF DEATH<br>July 30, 1953  |  |                                       |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |  |   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY BALTO. |  |                                       |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION 4700 Harford Rd.<br>Harford Convalescent Home   |  |  |   |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Towson                                 |  |                                       |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |  |  |   |  |  | D. STREET ADDRESS (If rural, give location)<br>1405 Gateshead Rd.  |  |                                       |  |  |
| 5. SEX<br>female  |  | 6. COLOR OR RACE<br>white                    |   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed |  | 8. DATE OF BIRTH<br>Oct. 23, 1863  |  | 9. AGE (In years last birthday)<br>89 |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife  |  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY                          |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?          |  |  |
| 13. FATHER'S NAME<br>Benjamin J. Sedwick  |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME<br>Agnes Peterson   |  |                                       |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) No  |  |  |   | 16. SOCIAL SECURITY NO.<br>no                              |  | 17. INFORMANT ADDRESS<br>Mr. Lawrence S. Gwyn-1405 Gateshead Rd.   |  |                                       |  |  |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Cardiac Decompensation<br>DUE TO<br>(B) Generalized Arterio-sclerosis<br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 week<br>Feb. 1946 |  |  |   |  |  | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.      |  |                                       |  |  |
| 19A. DATE OF OPERATION  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  |                                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |                                       |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?   |  |                                       |  |  |
| 22. I hereby certify that I attended the deceased from Feb. 1946 to 7-30-1953, that I last saw the deceased alive on 7-30-1953, and that death occurred at 10:15 a.m., from the causes and on the date stated above.  |  |  |   |  |  |  |  |                                       |  |  |
| 23A. SIGNATURE<br>Polonia Plazonia  |  |  |   |  |  | 23B. ADDRESS<br>2424 Eutan Place   |  | 23C. DATE SIGNED<br>7-31-53           |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>8/1/53                          |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.     |  | 24D. LOCATION (City, town, or county)<br>Balto., Md.   |  |                                       |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>AUG 1 1953  |  | REGISTRAR'S SIGNATURE<br>Huntington Williams |   |  |  | 25. FUNERAL DIRECTOR<br>Wm. J. Tiekner & Sons  |  | ADDRESS<br>Watts 17th                 |  |  |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

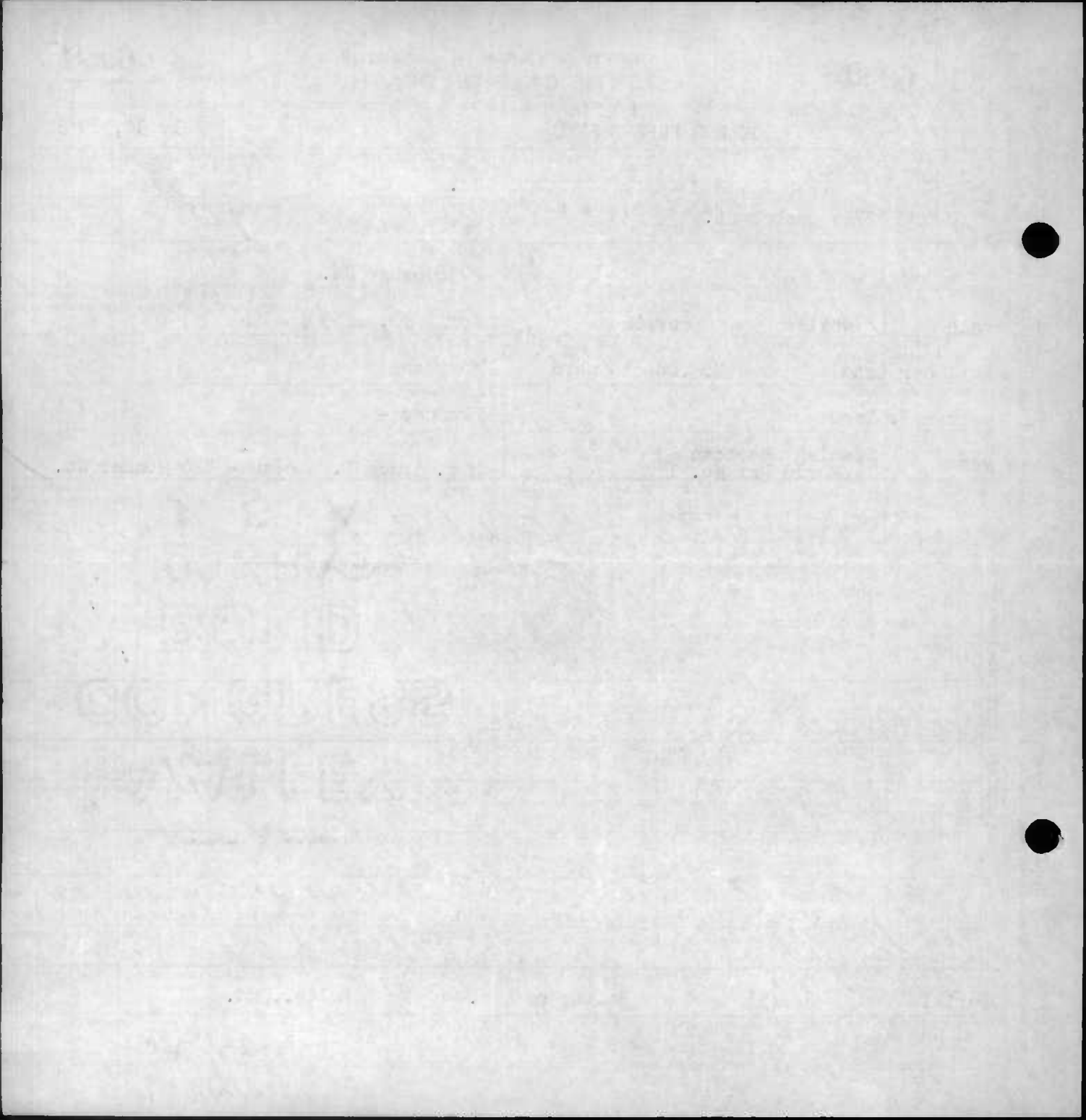
MARGIN RESERVED FOR BINDING

R-300  
53 6969

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6969  
Registered No.

|   |                           |  |  |  |   |
|---|---------------------------|--|--|--|---|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH   |   |
|   |                           | GEORGE ROBERT REED   |  | July 30, 1953  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md. |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>2736 Mosher St.  |                           |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore                |  |   |
| c. Length of stay in Baltimore  |                           |  | D. STREET ADDRESS (If rural, give location)<br>2736 Mosher St.   |  |   |
| 5. SEX<br>male  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married   | 8. DATE OF BIRTH<br>April 30, 1859   | 9. AGE (In years last birthday)<br>94  | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Engineer (rtd)   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>U.S. Coast Guard  | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?                                |
| 13. FATHER'S NAME<br>George R. Reed   |                           |  | 14. MOTHER'S MAIDEN NAME<br>Frances -  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>yes   |                           | 16. SOCIAL SECURITY NO.<br>Spanish American & World War No. 1  |  | 17. INFORMANT ADDRESS<br>Mrs. Grace R. Paterson-2736 Mosher St.  |   |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Cerebral Thrombosis<br>DUE TO Cerebral Arteriosclerosis<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C) |                           |  | INTERVAL BETWEEN ONSET AND DEATH<br>7-25-53  |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>None   |                           |  |  |  |   |
| 19A. DATE OF OPERATION  |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20. AUTOPSY? CAUSE OF DEATH, ENTER IN PART I OR PART II<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from 7/25, 1953, to 7/30/53, 1953, that I last saw the deceased alive on 7/30, 1953, and that death occurred at 5:55 a.m., from the causes and on the date stated above.  |                           |  |  |  |   |
| 23A. SIGNATURE<br>Stan Belman   |                           | 23B. ADDRESS<br>1201 Poplar Grove St.  |  | 23C. DATE SIGNED<br>7-31-53  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>8/3/53  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.   |   |
| 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.  |                           | 24E. FUNERAL DIRECTOR<br>Huntington Williams   |  | 24F. ADDRESS<br>1914 M. J. Fisher & Sons<br>Balto. 17, Md.   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>AUG 1 1953  |                           | REGISTRAR'S SIGNATURE  |  | 24G. ADDRESS   |   |
| VS 150  |                           |  |  |  |   |





H-220

53 6970

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6970

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Phoebe Hughes

2. DATE  
OF  
DEATH 7/30/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)

Lincoln Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Md.

Balto.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

5220 Denmore Ave.

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Sep

Sep

8. DATE OF BIRTH

3/7/76

9. AGE (In years  
last birthday)

77

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

Blind Pensioner

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Chas. Maynard

14. MOTHER'S MAIDEN NAME

Sara. Arne ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mary E. Ross 5220 Denmore Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH

Hypertension & Cardiac Vascular  
DiseaseINTERVAL BETWEEN  
ONSET AND DEATH

3 mos.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH. ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-28, 1953, to 7-30, 1953, that I last saw the  
deceased alive on 7-30, 1953, and that death occurred at 8:44 m., from the causes and on the date stated above.

23A. SIGNATURE

Phoebe Hughes

M. D.

23B. ADDRESS

558 Mc Mechen St

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/3/53

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presstman St.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **53 6971**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

BROWN, JR.

2. DATE  
OF  
DEATH

July 29, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

C. Length of stay in Baltimore

7 yrs

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

516 Norris Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

7/30/30

9. AGE (In years  
last birthday)

23

If Under 1 Year

Months

If Under 24 Hours

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Intrusion Prepack Co

11. BIRTHPLACE (State or foreign country)

Valdosta, Ga.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Brown, Sr.

14. MOTHER'S MAIDEN NAME

Lillie Mae Pollack

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

255-34-0277

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Enoch Wilson 516 Norris St.

ADDRESS

Balto. Md.

INTERVAL BETWEEN  
ONSET AND DEATH

18. E 851X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pennsylvania Railroad pier at Clinton St.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 29, 1953 9:50 A. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐21F. HOW DID INJURY OCCUR? Fell overboard & 2636  
drowned when barge struck pylon in water22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. J. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
July 29, 195324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Valdosta, Ga.

8/1/53

Vladosta, Ga.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

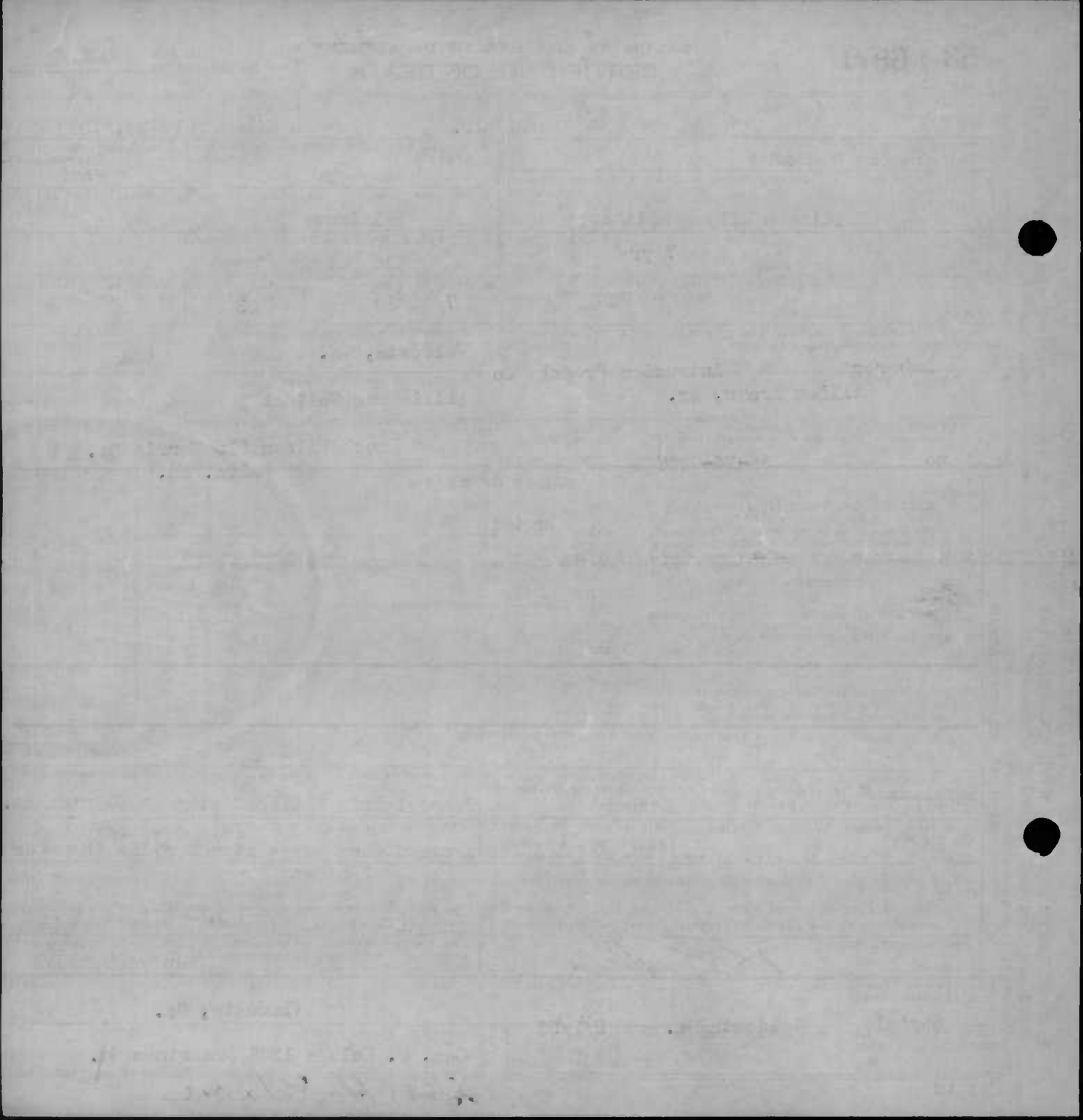
ADDRESS

Geo. G. Kelson 1303 Presstman St.

VS 151

N 990X

970 99 Geo. G. Kelson



53 6972

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6972

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *Thomas Daniels*

2. DATE OF DEATH *July 28, 1953*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *Acct Room*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE *md.* B. COUNTY *7/6/53*

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION *JOHNS HOPKINS HOSPITAL*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore*

7. STREET ADDRESS (If rural, give location)  
*1607 W. Linnale St*

8. Length of stay in Baltimore *?* Yrs. Mos. Days

9. SEX *Male*

10. COLOR OR RACE *Colored*

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Married*

12. DATE OF BIRTH *6/13/04*

13. AGE (In years last birthday) *49*

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*La Porter*

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)  
*Va*

19. CITIZEN OF WHAT COUNTRY?  
*USA*

20. FATHER'S NAME  
*Fre Daniels*

21. MOTHER'S MAIDEN NAME  
*Lizzie -*

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
*no*

23. SOCIAL SECURITY NO.  
*213-01-2685*

24. INFORMATION ADDRESS  
*JOHNS HOPKINS HOSPITAL*

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *CARCINOMA OF THE STOMACH*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

19C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 1953 to 7/28, 1953*, that I last saw the deceased *DOA* on *7/25, 1953*, and that death occurred at *4:20 P.*, from the causes and on the date stated above.

23A. SIGNATURE  
*A. W. Owens, Jr.*

23B. ADDRESS  
*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED  
*7-29-53*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE  
*8/1/53*

24C. NAME OF CEMETERY OR CREMATORY  
*Mt Auburn*

24D. LOCATION (City, town, or county) (State)  
*Balto. Md*

25. FUNERAL DIRECTOR  
*Geo. H. Kelso*

26. ADDRESS  
*1303 Presidentman St*

VS 150

Released to Hospital 97099

NOT A MEDICAL EXAMINER'S CASE

*[Signature]*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER



| 630   |                  | 3/1/54 ES  |                  | 53 6973   |                  | 53 6973  |            |
|---|------------------|--|------------------|---|------------------|--|------------|
| AB-171014   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                  | CERTIFICATE OF DEATH  |                  | Registered No.   |            |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE OF DEATH  |                  | Mary Ford  |            |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |                  | B. COUNTY   |                  | Maryland   |            |
| 8. FULL NAME OF (If not in hospital or institution, give street address or location)  |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)                           |                  | D. STREET ADDRESS (If rural, give location)   |                  | Baltimore  |            |
| Baltimore City Hospitals<br>4940 Eastern Ave.   |                  | Baltimore  |                  | 1520 E. Chase St. zone 13   |                  | 8-07   |            |
| c. Length of stay in Baltimore  |                  | 15yrs  |                  | Yrs. Mos. Days  |                  |  |            |
| 5. SEX  | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH | 9. AGE (In years last birthday)   | 10. Under 1 Year | 11. Under 24 Hours   |            |
| F   | N                | Widowed  | June 12-1919     | 34  | Months           | Days   | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                  | 12. CITIZEN OF WHAT COUNTRY?   |            |
| Laborer   |                  | General  |                  | Va.   |                  |  |            |
| 13. FATHER'S NAME   |                  | 14. MOTHER'S MAIDEN NAME   |                  | 17. INFORMANT   |                  | ADDRESS  |            |
| unborn  |                  | Laura Winn   |                  | 4940 Eastern Ave.   |                  | Records: Baltimore City Hospitals  |            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                  | 16. SOCIAL SECURITY NO.  |                  | 18. CAUSE OF DEATH  |                  | INTERVAL BETWEEN ONSET AND DEATH   |            |
|   |                  |  |                  | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |                  |  |            |
|   |                  |  |                  | (A) Rupture of Esophagus  |                  |  |            |
|   |                  |  |                  | DUE TO  |                  |  |            |
|   |                  |  |                  | 2. ANTECEDENT CAUSES  |                  |  |            |
|   |                  |  |                  | (B) Pneumonia   |                  |  |            |
|   |                  |  |                  | DUE TO  |                  |  |            |
|   |                  |  |                  | (C) Generalized Peritonitis   |                  |  |            |
|   |                  |  |                  | Perforated duodenal ulcer   |                  |  |            |
|   |                  |  |                  | 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |            |
|   |                  |  |                  | Malignant hypertension  |                  |  |            |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  |                  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                  |  |            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?  |                  |  |            |
| 22. I hereby certify that I attended the deceased from 6-8-1953, to 7-29-1953, that I last saw the deceased alive on 7-29-1953, and that death occurred at 9A m., from the causes and on the date stated above. |                  | 23A. SIGNATURE   |                  | 23B. ADDRESS  |                  | 23C. DATE SIGNED   |            |
| H. J. Schuman   |                  | 4940 Eastern Ave., Baltimore, Md.  |                  | 7-29-53   |                  |  |            |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 24B. DATE  |                  | 24C. NAME OF CEMETERY OR CREMATORY  |                  | 24D. LOCATION (City, town, or county) (State)                                    |            |
| Burial  |                  | 8/1/53   |                  | Mt. Auburn  |                  |  |            |
| DATE RECEIVED BY LOCAL REGISTRAR  |                  | REGISTRAR'S SIGNATURE  |                  | 25. FUNERAL DIRECTOR  |                  | ADDRESS  |            |
|   |                  | Huntington Williams  |                  | A. Halsted  |                  | 915-   |            |
| VS 150  |                  | 97099  |                  | Hill ave.   |                  |  |            |

See query reply in Document file.

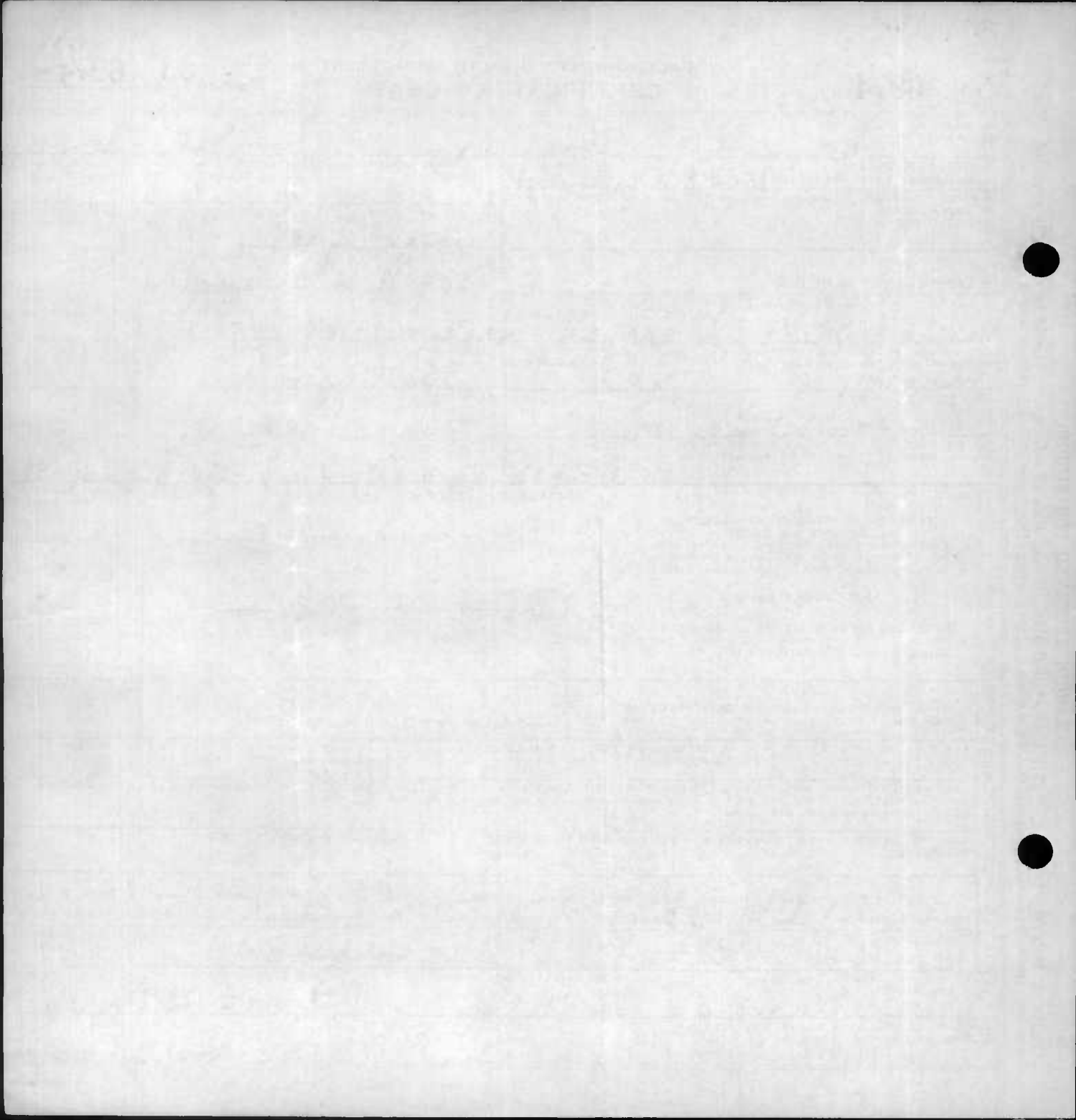
*reply to query*

PFEIFER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. **53 6974**

**53 6974**  
BIRTH NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Emil H. Pfeifer</b>  |  |  | 2. DATE OF DEATH<br><b>July - 30 - 1953</b>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>1509 N. Washington St</b>   |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>8-07</b> |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>W</b>  |  |  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                      |   |  |
| 7. STREET ADDRESS (If rural, give location)<br><b>1509 N. Washington St.</b>   |  |  | 8. DATE OF BIRTH<br><b>September - 29 - 1891</b>  |   |  |
| 9. SEX<br><b>Male</b>  |  |  | 10. AGE (In years, last birthday) <b>55</b>   |   |  |
| 11. COLOR OR RACE<br><b>White</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  |
| 13. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   |  |  | 14. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>   |   |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Barber</b>  |  |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>Self</b>   |   |  |
| 17. FATHER'S NAME<br><b>George Pfeifer</b>   |  |  | 18. MOTHER'S MAIDEN NAME<br><b>Julia Yeager</b>   |   |  |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  | 20. SOCIAL SECURITY NO.<br><b>215-32-3433</b>   |   |  |
| 21. INFORMANT<br><b>Dorance M. Pfeifer</b>   |  |  | 22. ADDRESS<br><b>1509 N. Wash St</b>   |   |  |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary occlusion</b><br>DUE TO<br><b>4 hrs</b> |  |  |   |   |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Coronary insufficiency</b><br>DUE TO<br><b>2 yrs</b>  |  |  |   |   |  |
| 20. II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Phlebotomy - not long.</b>  |  |  |   |   |  |
| 21A. DATE OF OPERATION<br><b>0</b>   |  | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 21C. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II |  |
| 22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 22B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)              |   | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?    |  |
| 23A. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 23B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 23C. HOW DID INJURY OCCUR?  |  |
| 24. I hereby certify that I attended the deceased from <b>Jan 1948</b> to <b>July 30, 1953</b> that I last saw the deceased alive on <b>July 29, 1953</b> and that death occurred at <b>13<sup>30</sup> AM.</b> from the causes and on the date stated above.              |  |  |   |   |  |
| 25A. SIGNATURE<br><b>Donald L. Richter</b>   |  | 25B. ADDRESS<br><b>3128 Harford Rd</b>   |   | 25C. DATE SIGNED<br><b>7/30/53</b>  |  |
| 26A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 26B. DATE<br><b>Aug. 3 - 53</b>  |   | 26C. NAME OF CEMETERY OR CREMATORY<br><b>Balto Cem.</b>                     |  |
| 26D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>   |  | 26E. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>                                       |   |   |  |
| 27. DATE RECEIVED BY LOCAL REGISTRAR<br><b>AUG 1 1953</b>  |  | 27A. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |   | 27B. FUNERAL DIRECTOR<br><b>John P. Phillips</b>                            |  |
| 27C. ADDRESS<br><b>2431 E. Olive St</b>  |  | 27D. ADDRESS<br><b>2431 E. Olive St</b>  |   |   |  |



MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

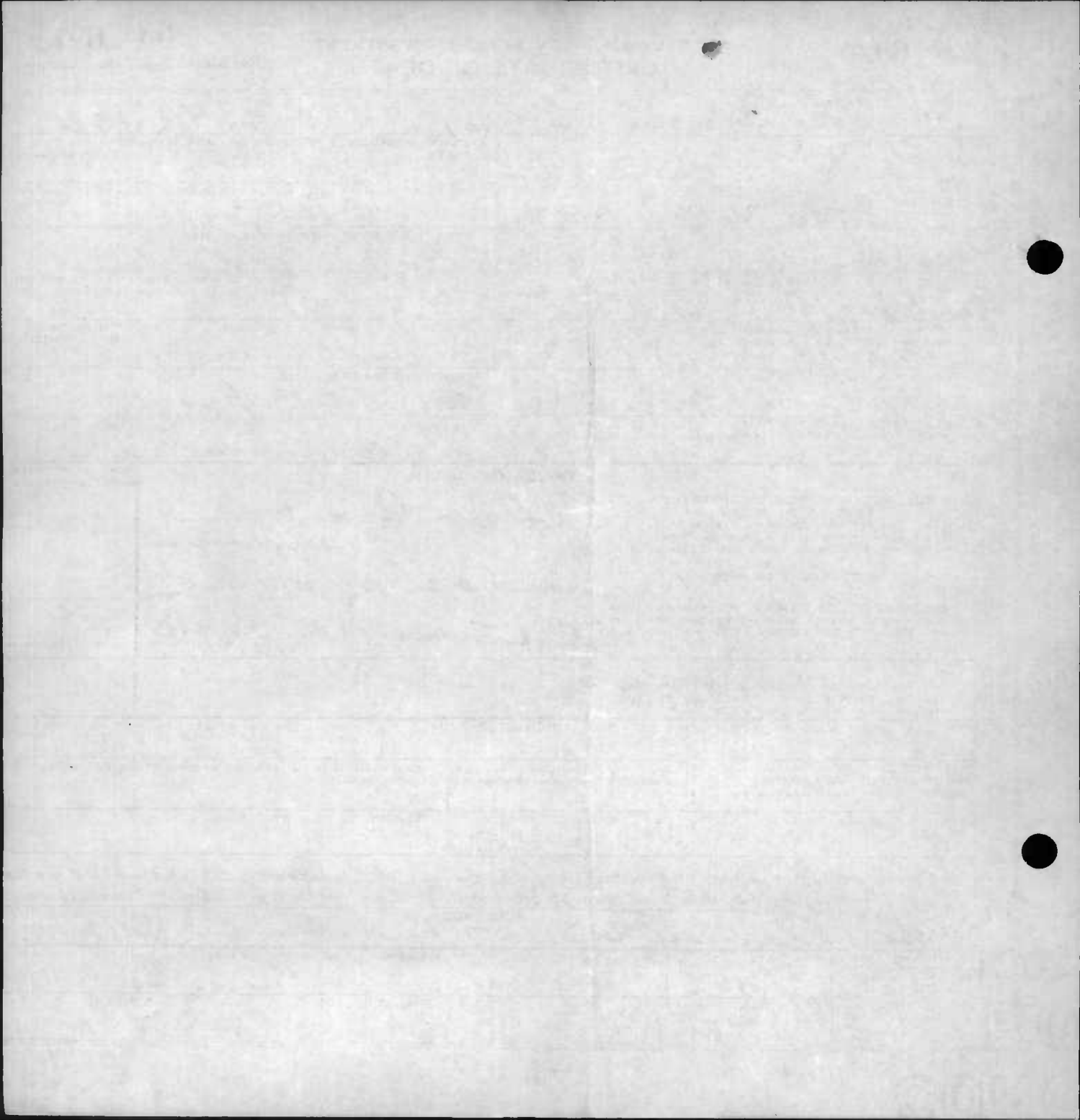
53 6975  
Registered No.

4-560  
53 6975  
A 262  
BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>May Henry (Akers)</i>   |                                  | 2. DATE OF DEATH<br><i>7/30/53</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>3520 Hilton Rd</i> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. 10-01</i>                    |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>404 E. Chase st.</i>   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  | 8. DATE OF BIRTH<br><i>10/17/1879</i>        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>at home</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Self</i>   | 9. AGE (In years last birthday)<br><i>73</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Balto. md.</i>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><i>Charles L. Sneed</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Margaret V. Knight</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)      |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><i>Edna Williamson</i>   |                                  | ADDRESS<br><i>404 E. Chase st.</i>   |  |

|   |  |  |  |                                  |
|---|--|--|--|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>151X I</i> |  | CAUSE OF DEATH<br><i>Massive Gastrointestinal Hemorrhage</i> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | DUE TO<br><i>Carcinoma of stomach</i>                        |  |                                  |
|   |  | DUE TO<br><i>Hypertensive- Art. C.V. &amp; D.</i>            |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |                                  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19A. DATE OF OPERATION<br><i>0</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <i>June 1953</i> to <i>July 30, 1953</i> , that I last saw the deceased alive on <i>July 30, 1953</i> and that death occurred at <i>3:15 P.M.</i> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><i>William Resperced</i>   |  | 23B. ADDRESS<br><i>2511 Resperced Rd.</i>   |  | 23C. DATE SIGNED<br><i>7/31/53</i>                                       |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24B. DATE<br><i>8/3/53</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine</i>                    |  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Co. md.</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>AUG 1 1953</i>  |  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |  | 25. FUNERAL DIRECTOR<br><i>W. M. Cook Inc.</i>                           |  | ADDRESS<br><i>1217 St. Paul St.</i>                                      |  |





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 6976

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6976

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SALLIE L. SAPP

2. DATE  
OF  
DEATH

JULY 30, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)

FAYETTE CONVALESCENT HOME

33

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write full name of town, village, or township)

BALTIMORE 10-02

D. STREET ADDRESS (If rural, give location)

914 WILMONT COURT

c. Length of stay in Baltimore

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

JAN 1, 1875

9. AGE (In years last birthday)

78

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

PLEASANT GROVE, VA. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GEORGE W. LOWERY

14. MOTHER'S MAIDEN NAME

SARA LOWERY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

FLORENCE L. WILKES

18. E900.0

CAUSE OF DEATH

1615 LEWELLYN

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONIA

3 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) FRACTURE, RT FEMUR

3 MO

CERTIFICATION APPROVED BY

*William H. Smith* M.D.  
CHIEF OF ASSOCIATE MEDICAL EXAMINER

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

914 Wilmont Court 10/2

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

5/2/53

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down stair steps

22. I hereby certify that I attended the deceased from MAY 25, 1953, to JULY 30, 1953, that I last saw the deceased alive on JULY 29, 1953, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

C.B. Case for John B. DeHoff

23B. ADDRESS

112 W 25th St.

23C. DATE SIGNED

JULY 30, 1953

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/3/53

24C. NAME OF CEMETERY

Moulton Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William H. Smith*

25. FUNERAL DIRECTOR

Wm. Corbett, 1217 St. Paul St.

VS 150

N 821.0

*[The page contains faint, illegible markings and two punch holes.]*

MARGIN RESERVED FOR BUILDING  
PLEASE WRITE PENNLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-520

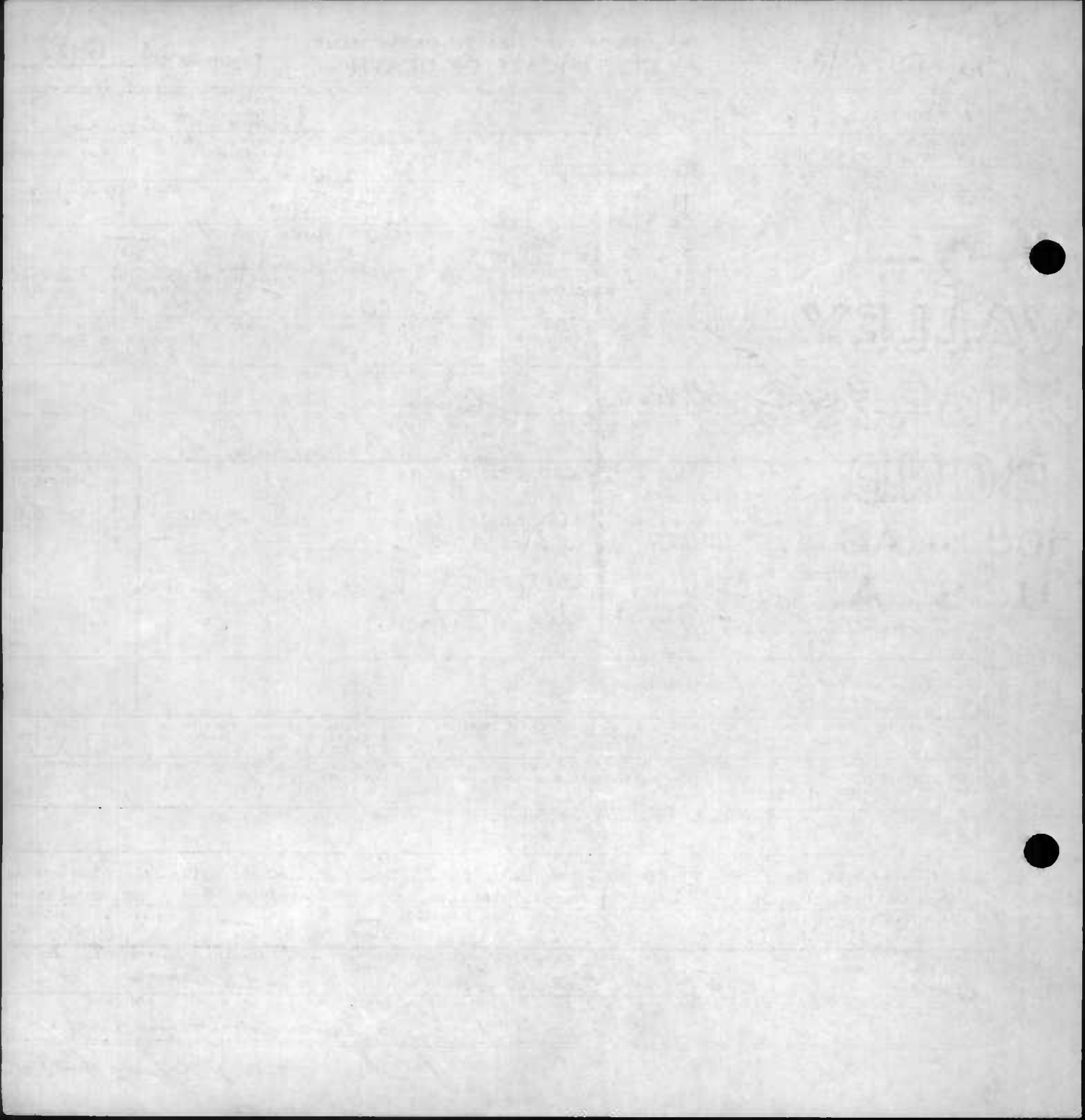
53 6977

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6977

|  |   |   |  |
|--|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Myrtle Baranowski</b>  |   | 2. DATE OF DEATH<br><b>7/30/53</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>University Hospital</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 1-04</b>                       |  |
| c. Length of stay in Baltimore<br><b>30 yrs</b>  |   | D. STREET ADDRESS (If rural, give location)<br><b>2236 Cambridge St</b>   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>12/18/00</b>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) Months Days<br><b>53</b>                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ill</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John Green</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Frank Baranowski</b>   |   | ADDRESS<br><b>same</b>  |  |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary heart disease &amp; myocardial failure, old &amp; recent &amp; complete heart block duct myocardial infarction.</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month.</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 1</b> , 19 <b>53</b> , to <b>July 30</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>July 30</b> , 19 <b>53</b> , and that death occurred at <b>11:24</b> m., from the causes and on the date stated above.   |   |   |  |
| 23A. SIGNATURE<br><b>Carl H. Weaver</b>  |   | 23B. ADDRESS<br><b>University Hospital</b>  | 23C. DATE SIGNED<br><b>July 30, 1953</b>                                 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>8-3-53</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>     |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>H. H. H. Williams</b>   | 25. FUNERAL DIRECTOR<br><b>Lilly &amp; Zidench</b>  | ADDRESS<br><b>403 S. Weber St.</b>                                       |



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-620  
53 6978

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

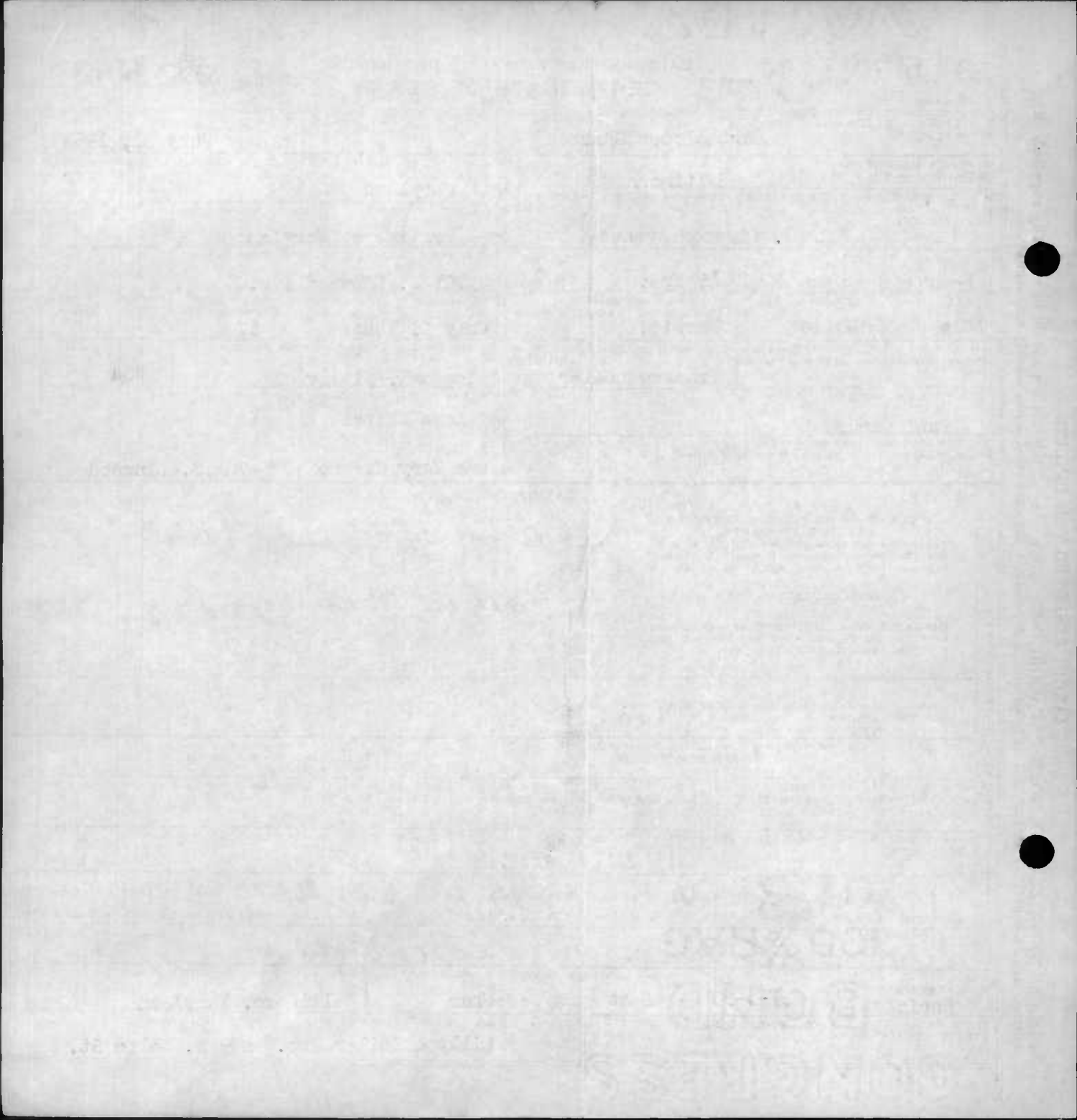
Registered No. 53 6978

BIRTH NO.

|   |                           |  |                                  |   |  |
|---|---------------------------|--|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | Bartholomew Caruso   |                                  | 2. DATE OF DEATH<br>July 31, 1953   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | Baltimore  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>701 S. Linwood Avenue                            |                           | C. CITY OR TOWN<br>Baltimore, Maryland                     |                                  | D. STREET ADDRESS (If rural, give location)<br>701 S. Linwood Ave.  |  |
| c. Length of stay in Baltimore<br>47 Yrs.   |                           | Yrs.<br>Mos.<br>Days                                       |                                  |   |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married | 8. DATE OF BIRTH<br>July 9, 1886 | 9. AGE (In years last birthday)<br>67   | 11. BIRTHPLACE (State or foreign country)<br>Trapani, Sicily |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Produce Dealer        |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Paul Caruso  |                           | 14. MOTHER'S MAIDEN NAME<br>Anna Maltese                   |                                  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No                     |                           | 16. SOCIAL SECURITY NO.                                    |                                  | 17. INFORMANT<br>Mrs Mary Caruso  |  |
|   |                           |  |                                  | ADDRESS<br>701 S. Linwood   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>331X I |  | CAUSE OF DEATH<br>(A) Coronary Thrombosis July 31, 1953<br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br>1953 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) Cerebral Hemorrhage July 7, 1953<br>DUE TO                    |  | 1953                                     |  |
|  |  | (C)   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19A. DATE OF OPERATION<br>0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                     |  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from July 19, 1953, to Aug 31, 1953, that I last saw the deceased alive on Aug 31, 1953, and that death occurred at 10:20 am., from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br>William S. Beckman   |  | M. O.<br>3526 South M  |  | 23B. ADDRESS   |  | 23C. DATE SIGNED<br>Aug 31-53  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>8-5-53  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer                 |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland     |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>AUG 1 1953   |  | REGISTRAR'S SIGNATURE<br>Huntington Williams   |  | 25. FUNERAL DIRECTOR<br>Lilly & Zeiler Inc.                              |  | ADDRESS<br>403 S. Wolfe St.  |  |





R-210

53 6979

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6979  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LESTER F. RAYCOB

2. DATE  
OF  
DEATH

August 1, 1953

3. PLACE OF DEATH:

Baltimore City, Maryland

4. FULL NAME OF (If not in hospital or institution, give street address or location)

SOUTH BALTIMORE GENERAL HOSPITAL

Yrs.  
Mos.  
Days

5. Length of stay in Baltimore

6. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 18 1891

9. AGE (In years  
last birthday)

62

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PRIVATE CHAUFFEUR

10B. KIND OF BUSINESS OR  
INDUSTRYDOMESTIC  
PERSONAL SERVICE

11. BIRTHPLACE (State or foreign country)

BALTO. MD

MARY LAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY A. RAYCOB

14. MOTHER'S MAIDEN NAME

LOUISA KING

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR. CHARLES RAYCOB 5-606 PURDUE AVE

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) MYOCARDIAL INFARCTION  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) CORONARY THROMBOSIS  
DUE TO  
(C) CORONARY ARTERIOSCLEROSISII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

ARTERIO SCLEROSIS, GENERAL

INTERVAL BETWEEN  
ONSET AND DEATH

May 18 to Aug 1, 1953

May 18 to Aug 1, 1953

1953

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 30<sup>th</sup>, 1953, to AUGUST 1, 1953, that I last saw the  
deceased alive on AUGUST 1, 1953, and that death occurred at 2:35 Am., from the causes and on the date stated above.

23. SIGNATURE

Donald Benner

23B. ADDRESS

SOUTH BALTIMORE GEN. HOSPITAL

23C. DATE SIGNED

8-1-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

8/4/53

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE

24D. LOCATION (City, town, or county)

BALTO. MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

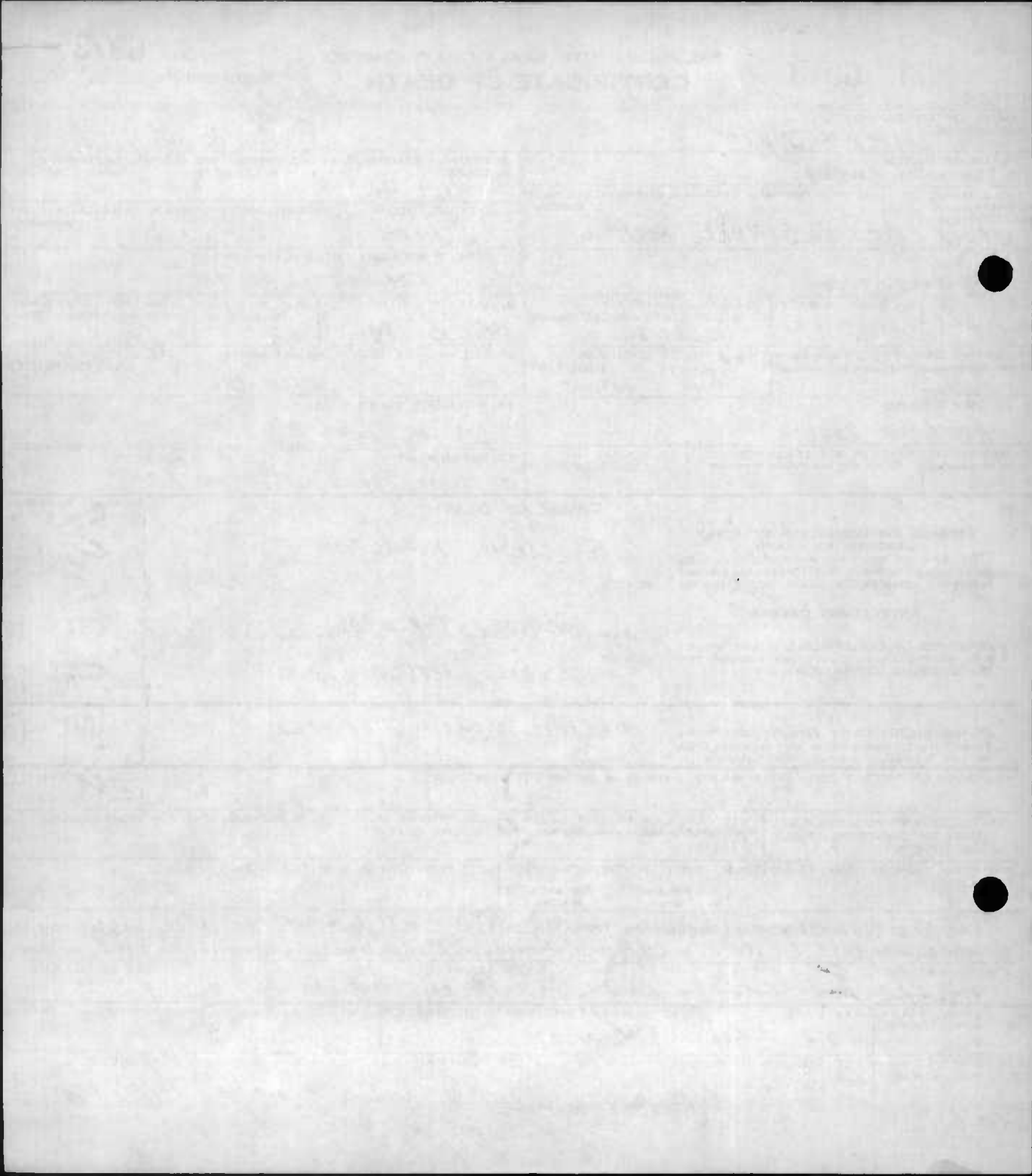
25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tucker, 1000 Pine Ball's Rd

VS 153

6828A



E-251  
53 6980BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6980  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CATHERINE SOPHIA EISENBRANDT

2. DATE  
OF  
DEATH

July 31, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2226 Crest Rd.

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2226 Crest Rd.

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

F

W

Widowed

Aug. 17, 1861

91

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Alexander H. Schulz

14. MOTHER'S MAIDEN NAME

Mary Hauser

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

No

17. INFORMANT

ADDRESS

Mrs. Alexander Eisenbrandt

Above

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Myocardial Failure.

6 hrs.

Chronic Osteosclerotic Cardiovascular  
Disease.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1943 to July 31, 1953 that I last saw the  
deceased alive on July 31, 1953 and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

8/3/53

Druid Ridge

Pikesville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

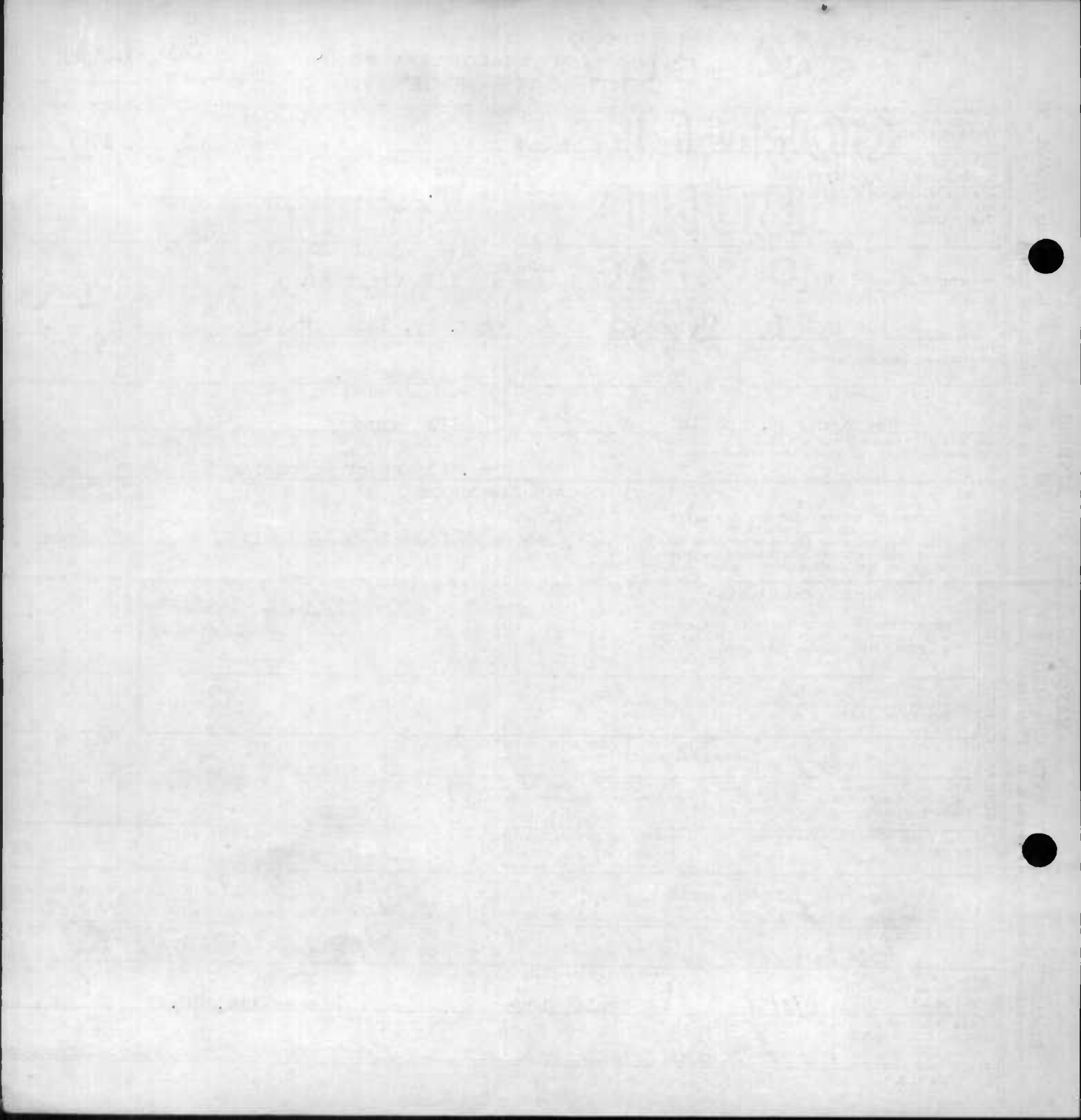
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-236

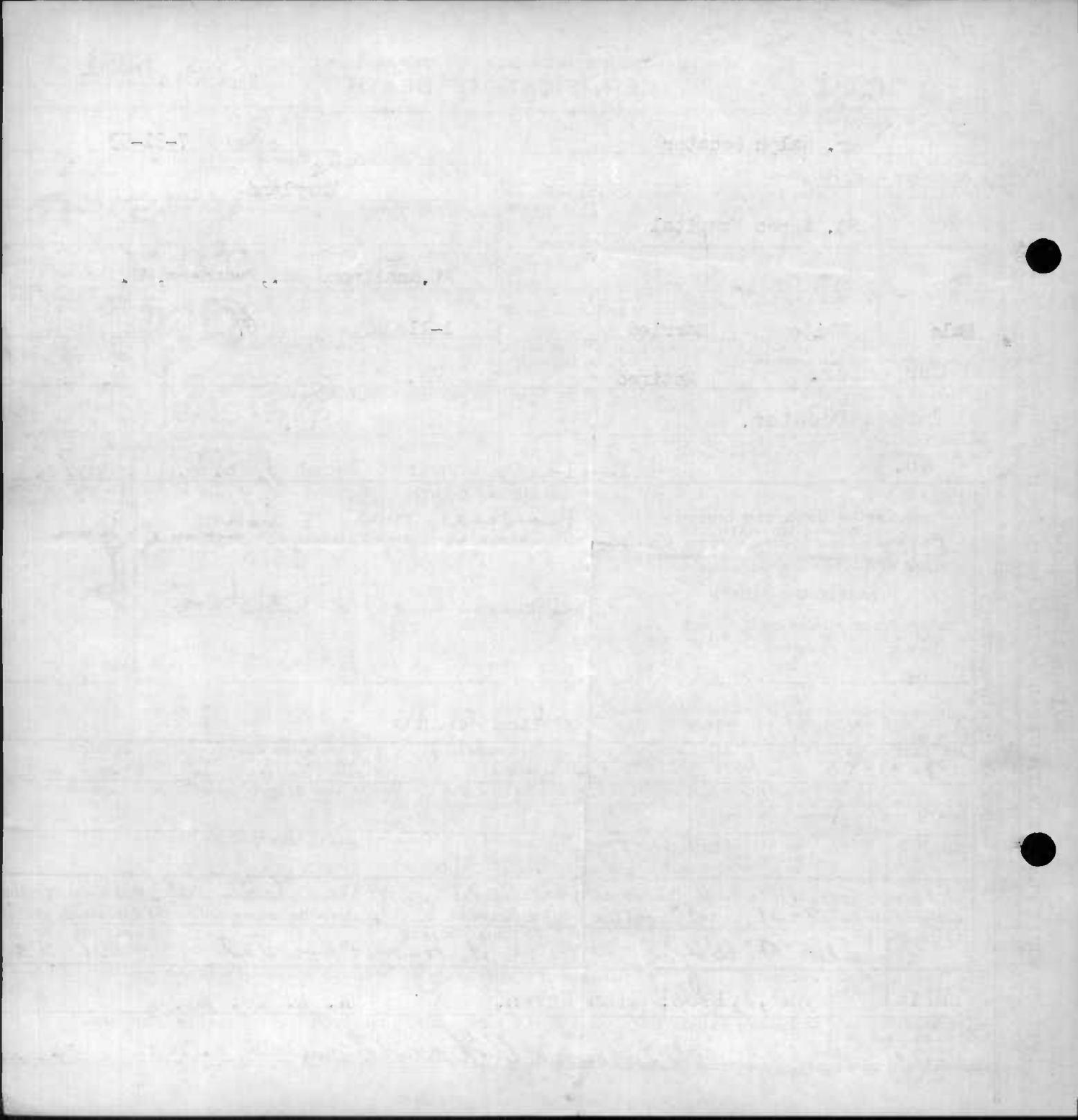
53 6981

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 53 6981  
Registered No.

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. Ralph Decator</b>   |                                  | 2. DATE OF DEATH<br><b>7-31-53</b>  |                                     |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> |                                     |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Agnes Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>5200</b>   |                                     |
| c. Length of stay in Baltimore <b>10 Days.</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>Ft. Smallwood Rd., Pasadena, Md.</b>  |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>1-11-86.</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter.</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |                                     |
| 13. FATHER'S NAME<br><b>Thomas Decator.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>212-01-5899</b>   |                                     |
| 17. INFORMANT<br><b>Margaret Decator, Ft. Smallwood Rd.</b>   |                                  | ADDRESS   |                                     |
| 18. <b>162x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hemiparesis, right &amp; massive collapse, right lung; post-op</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b>  |                                     |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Carcinoma lung, &amp; metastases</b>   |                                  |   |                                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>osteoarthritis</b>   |                                  |   |                                     |
| 19A. DATE OF OPERATION<br><b>7-31-53</b>  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA lung</b>  |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   |                                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                                     |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21F. HOW DID INJURY OCCUR?  |                                     |
| 22. I hereby certify that I attended the deceased from <b>7-21-53</b> , to <b>7-31</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-31</b> , 19 <b>53</b> , and that death occurred at <b>6:50</b> P. M., from the causes and on the date stated above.                      |                                  |   |                                     |
| 23A. SIGNATURE<br><b>Donald R. Wolfel</b>   |                                  | 23B. ADDRESS<br><b>St. Agnes Hospital</b>   |                                     |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>Aug. 3, 1953</b>  |                                     |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven.</b>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>A. A. Co. Md.</b>   |                                     |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                  | 25. FUNERAL DIRECTOR<br><b>1400 S. Charles St.</b>  |                                     |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |                                  | ADDRESS<br><b>51024</b>   |                                     |

AUG 2 1953





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-160

53 6982

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6982  
Registered No.

BIRTH NO.

|  |                              |   |   |  |   |
|--|------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MRS. CLARA SEAUER</b>  |                              |   | 2. DATE OF DEATH<br><b>8-1-1953</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Allegany</b> |  |   |
| B. FULL NAME OF (If not in-hospital or institution, give street address or location)<br><b>40 ST. AGNES HOSPITAL</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Cumberland 5102</b>                                      |  |   |
| c. Length of stay in Baltimore <b>8</b> Yrs. Mos. Days   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>610 Washington Street</b>   |  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b> | 8. DATE OF BIRTH<br><b>Nov. 21, 1867</b>  | 9. AGE (In years last birthday)<br><b>84</b> | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>           |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                     | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>—</b>                    |
| 13. FATHER'S NAME<br><b>William Walsh</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Marian Shave</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)             |                              | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Jenkins Memorial Hospital - Baltimore Md.</b>   |  |   |

|   |                                 |                                     |   |
|---|---------------------------------|-------------------------------------|---|
| 18. <b>154X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br><b>SEPSIS</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
|   | (A) DUE TO                      |                                     |   |
|   | (B) DUE TO                      | <b>Intestinal Obstruction</b>       |   |
|   | (C)                             | <b>Possible Carcinoma of Rectum</b> |   |

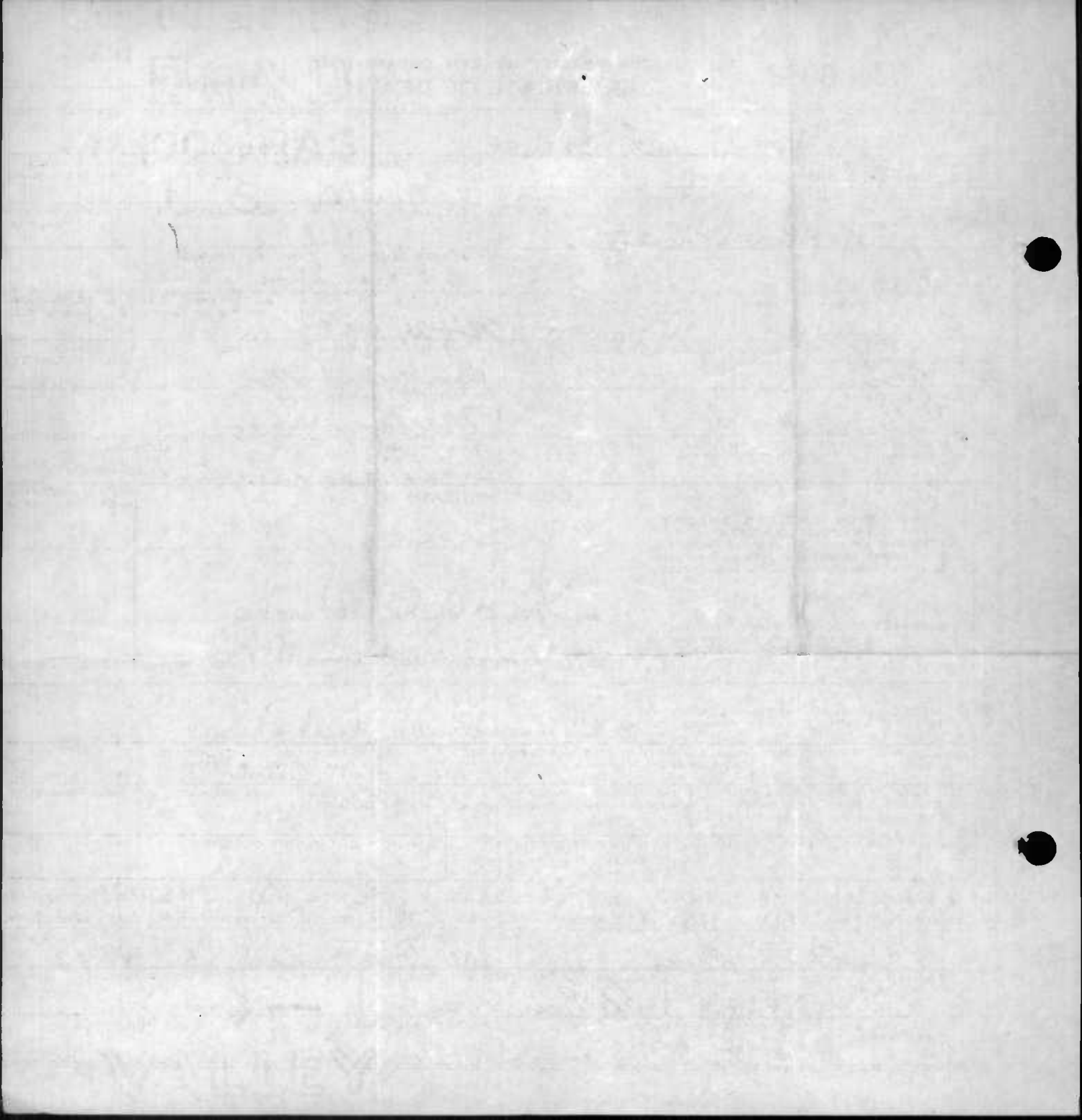
|   |   |  |   |
|---|---|--|---|
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Arteriosclerotic Heart Disease</b> |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |

|   |  |   |  |
|---|--|---|--|
| 22. I hereby certify that I attended the deceased from <b>7/30</b> , 19 <b>53</b> to <b>8/1</b> , 19 <b>53</b> that I last saw the deceased alive on <b>8/1</b> , 19 <b>53</b> , and that death occurred at <b>8:30</b> m., from the causes and on the date stated above. |  |   |  |
| 23A. SIGNATURE<br><b>Arnold L. Vance</b>  | M. D.  | 23B. ADDRESS<br><b>4105 Old Frederick Rd.</b>                     | 23C. DATE SIGNED<br><b>8/1/53</b>                                      |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>9/4/53</b>                   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter &amp; Paul</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Cumberland Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>H. W. Mearns</b> | 25. FUNERAL DIRECTOR<br><b>H. W. Mearns</b>                       | ADDRESS<br><b>805 N. Calvert St.</b>                                   |

AUG 2 1953 VS 150

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6983  
Registered No.

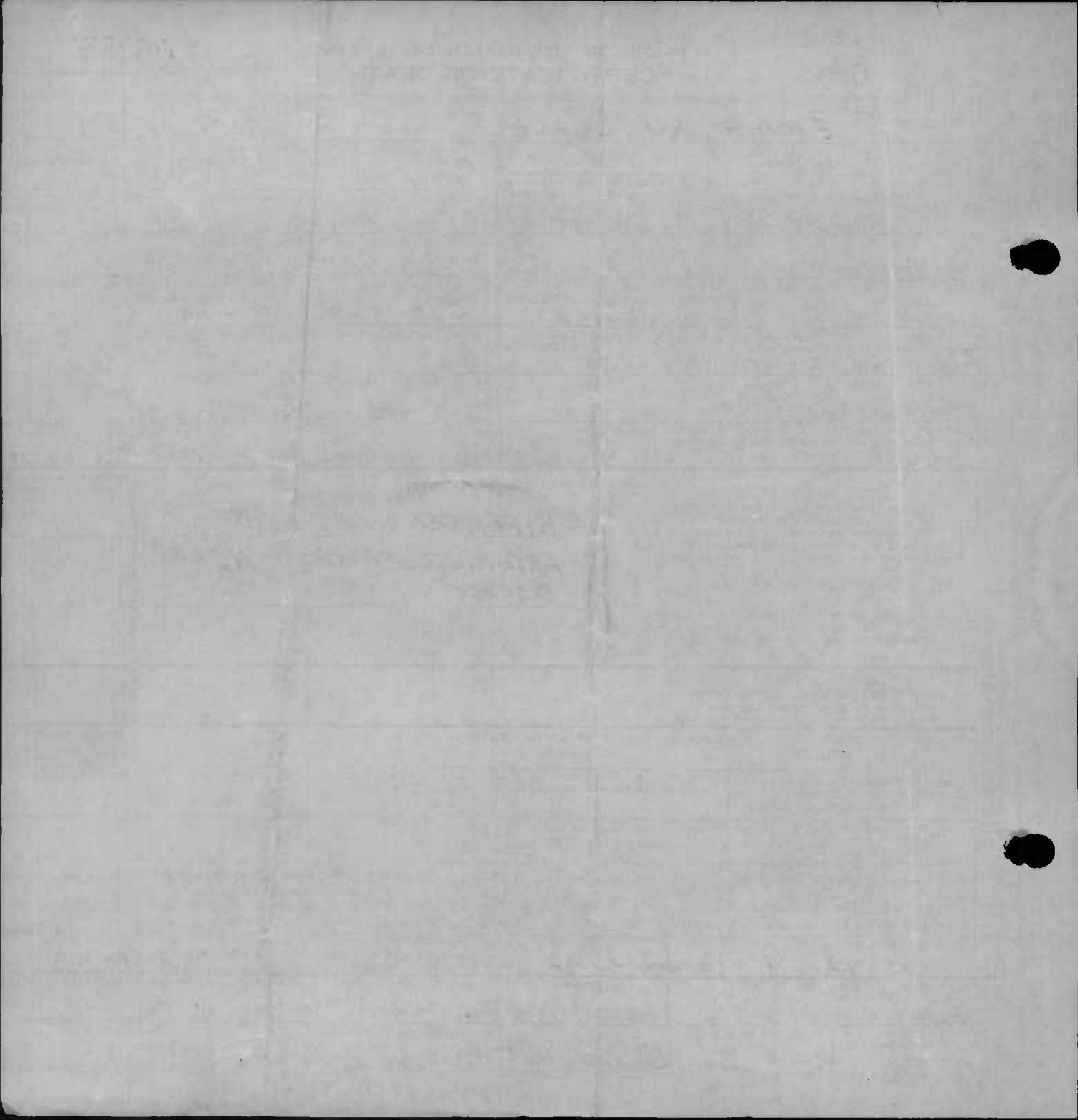
BIRTH NO. 53 6983

|   |                              |   |  |  |   |
|---|------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EMMA WALLACE</b>  |                              |   | 2. DATE OF DEATH <b>7/31/53</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>13-03</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2327 Mc Culloch St.</b>   |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b>  |  |   |
| C. Length of stay in Baltimore <b>50</b> Yrs. <b>Days</b>   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>2327 Mc Culloch St.</b>  |  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>C</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>Dec. 25, 1878</b>   |  | 9. AGE (In years last birthday)<br><b>74</b>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                              |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                              |   | 13. FATHER'S NAME<br><b>Geo. Walker</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Malinda Hickman</b>  |                              |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                  |  |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                              |   | 17. INFORMANT ADDRESS<br><b>Ada Lewis - 2327 Mc Culloch St</b>   |  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                     |  |                                  |
| (A) _____<br>(B) _____<br>(C) _____   |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>8/3/53</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                           |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>INSPECTION &amp; INQUIRY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph Q. Jachimczyk</b>   |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 23C. DATE SIGNED<br><b>8-1-53</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>8/3/53</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arboretum Mem. PK.</b>                     |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>Aug 2 1953</b>  |  | 24F. REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>                      |  |
| 24G. FUNERAL DIRECTOR<br><b>William I. Chatman, Jr.</b>   |  | 24H. ADDRESS<br><b>1701 Mc Culloch St.</b>  |  |   |  |

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6984  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Knight

2. DATE  
OF  
DEATH

July 30, 53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE Ind.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - 27-11

D. STREET ADDRESS (If rural, give location)

406 Keithway

c. Length of stay in Baltimore

50

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

3-4-80

9. AGE (In years last birthday)

73

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

President

11. INDUSTRY OR BUSINESS

Madison Properties Co.

12. BIRTHPLACE (State or foreign country)

Union Bridge, Carroll Co, Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Lepton Knight

14. MOTHER'S MAIDEN NAME

Lelah Locke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Obstructive Atelectasis - massive 15 min

Aspiration of vomitus

ANTECEDENT CAUSES

(B)

DUE TO

Cerebrovascular Accident 3 months

(C)

Hypertensive - Arteriosclerotic Vascular disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 29, 1953, to July 30, 1953, that I last saw the deceased alive on July 30, 1953, and that death occurred at 9:45 m., from the causes and on the date stated above.

23A. SIGNATURE

Malvin S. Brenthal

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

30 July 53

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 3 1953

24C. NAME OF CEMETERY OR CREMATORY

Landon Oak City, Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Ellis Lamoreau

ADDRESS

4510 Lehigh Ave

17. 12. 1904

17. 12. 1904

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6985  
Registered No.

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| BIRTH NO. 53 6985  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN H. RAYSINGER</b>   |  | 2. DATE OF DEATH<br><b>7/30/53</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>730 ASHBURTON ST.</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY |  |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 20-02</b>                    |  |   |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2509 W. FAIRMONT AVE.</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M.</b>  | 8. DATE OF BIRTH<br><b>OCT. 25, 1891</b> | 9. AGE (In years last birthday)<br><b>61</b>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WEIGHING + PAVING EMERSON DRUG CO.</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  | 13. FATHER'S NAME<br><b>Joseph H. Raysinger</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca C. Raysinger</b>                             |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, up or unknown) (If yes, give war or dates of service)<br><b>unknown</b>   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>W. H. C. Raysinger</b>                                  |  |
| 18. <b>332X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>MULTIPLE CEREBRAL THROMBOSIS</b>                      |                                  | CAUSE OF DEATH<br>(A) DUE TO<br><b>NOT DETERMINED</b>   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b>  |                                  | (B) DUE TO<br><b>HYPERTENSIVE C.V.D.</b>  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  | (C)   |  |   |  |
| 19A. DATE OF OPERATION   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>7/24</b> , 19 <b>53</b> to <b>7/30</b> , 19 <b>53</b> that I last saw the deceased alive on <b>7/30</b> , 19 <b>53</b> , and that death occurred at <b>2:53</b> p. m., from the causes and on the date stated above. |                                  |   |  |   |  |
| 23A. SIGNATURE<br><b>Paul H. Graham M.D.</b>   |                                  | 23B. ADDRESS<br><b>Luth. Hosp. BALTIMORE</b>  |  | 23C. DATE SIGNED  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial Aug 3/53</b>  |                                  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Western Bur. Balto. Md.</b>                |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |                                  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>AUG 2 1953</b>  |  | 24F. REGISTRAR'S SIGNATURE<br><b>Huntington</b>                                     |  |
| 24G. FUNERAL DIRECTOR<br><b>W. H. C. Raysinger</b>   |                                  | 24H. ADDRESS<br><b>6904R 1300 E. E. Place</b>   |  |   |  |

4

Liberty Bell  
Washington Monument

George Washington

George Washington  
Washington Monument

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

53 6986  
Registered No.

BIRTH NO.

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Emma S. Needles Dixon</i>  |                                  |   | 2. DATE OF DEATH<br><i>July 31-53</i>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>207 Henderson</i>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> COUNTY <i>Baltimore City</i> |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>at home</i>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-01</i>                                    |   |   |
| C. Length of stay in Baltimore <i>1 wk.</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>207 Henderson Road</i>  |   |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 8. DATE OF BIRTH<br><i>Feb 24/1860</i>  | 9. AGE (in years last birthday)<br><i>93</i>  | 10. Under 1 Year Months: Days: Min.         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>none</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>none</i>  | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> |
| 13. FATHER'S NAME<br><i>John W. Needles</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Augusta Stratton</i>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  | 17. INFORMANT<br><i>John P. Needles</i>   |   |   |
| 18. <i>443X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Myocarditis</i>                         |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>Gradual</i>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Atherosclerosis - Hypertension</i>  |                                  |   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |   |   |
| 19A. DATE OF OPERATION<br><i>7</i>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>July 7</i> to <i>July 31</i> , 19 <i>53</i> , that I last saw the deceased on <i>July 31</i> , 19 <i>53</i> , and that death occurred at <i>7 p.m.</i> , from the causes and on the date stated above. |                                  |   |   |   |   |
| 23A. SIGNATURE<br><i>W. P. Hardy</i>   |                                  | 23B. ADDRESS<br><i>1403 Park Ave</i>  |   | 23C. DATE SIGNED<br><i>8-1-53</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>buried</i>   |                                  | 24B. DATE<br><i>Aug-3-53</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Friends</i>                                |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Stanford 926 St.</i>   |                                  | 25. FUNERAL DIRECTOR<br><i>William M. ...</i>   |   |   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>AUG 2 1953</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |   |   |   |

CERTIFICATE OF DEATH

STATE OF NEW YORK

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P-620  
53 6987BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6987  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

John Louis Price

2. DATE  
OF  
DEATH

July 30th, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

614 S. Belnord Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

township)

D. STREET ADDRESS (If rural, give location)

614 S. Belnord Avenue

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 12, 1895

9. AGE (In years  
last birthday)

58

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Blacksmith

10B. KIND OF BUSINESS OR  
INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Price

14. MOTHER'S MAIDEN NAME

Pauline Kucinski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-07-0692

17. INFORMANT

ADDRESS

Catherine Price 614 S. Belnord Avenue

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Broncho-pneumonia

9 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Myocardial insufficiency

3 days

DUE TO

(C) Arterio-sclerosis, essential

?

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Depressive psychopathy

8 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19, 1944 to July 29, 1953, that I last saw the  
deceased alive on July 29, 1953, and that death occurred at 10:20 P. from the causes and on the date stated above.

23A. SIGNATURE

I. B. Bronushas, M.D.

23B. ADDRESS

3037 O'Donnell St., Baltimore, Md.

23C. DATE SIGNED  
JUL 31 195324A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

AUG-3, 1953

24C. NAME OF CEMETERY

St Stanislaus

24D. LOCATION (City, town, or county)

1300 Dundalk ave

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George A. Weber 705-S Ave

53-8531

DEPARTMENT OF HEALTH  
DIVISION OF HEALTH  
BUREAU OF VITAL STATISTICS

1953

Registration No.

CERTIFICATE OF DEATH

Decedent's Name

Age

Sex

Color

Marital Status

Place of Birth

Usual Residence

Occupation

Date of Death

Time of Death

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of Federal Registrar

Signature of National Registrar

Signature of International Registrar

Signature of World Registrar

Signature of Universal Registrar

Signature of Global Registrar

Signature of Planetary Registrar

Signature of Galactic Registrar

Signature of Cosmic Registrar

Signature of Universal Registrar

Signature of World Registrar

Signature of National Registrar

Signature of Federal Registrar

Signature of State Registrar

Signature of County Registrar

Signature of City Registrar

Signature of Town Registrar

Signature of Village Registrar

Signature of Hamlet Registrar

Signature of Estate Registrar

Signature of Personal Registrar

Signature of Social Registrar

Signature of Cultural Registrar

Signature of Religious Registrar

Signature of Political Registrar

Signature of Economic Registrar

Signature of Environmental Registrar

Signature of Global Registrar

2 X 2



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6988

53 6988  
BIRTH NO.

|   |                             |  |                          |  |   |
|---|-----------------------------|--|--------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)  |                             | CYRUS JEFFERSON  |                          | 2. DATE OF DEATH<br>July 29, 1953                            |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                          |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Provident Hospital   |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 16-03                      |                          |  |   |
| D. STREET ADDRESS (If rural, give location)<br>1020 Gilmore Street                                      |                             | c. Length of stay in Baltimore 55 yrs 4 mos 5 days   |                          |  |   |
| 5. SEX<br>male  | 6. COLOR OR RACE<br>colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH<br>1879 | 9. AGE (In years last birthday)<br>74 yrs.                   | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |                             | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country)<br>White Stone Va. |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                             | 13. FATHER'S NAME<br>Thomas Jefferson  |                          | 14. MOTHER'S MAIDEN NAME<br>Susan Curry                      |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                             | 16. SOCIAL SECURITY NO.  |                          | 17. INFORMANT<br>James Jefferson                             |   |
| 18. 443X  |                             | CAUSE OF DEATH   |                          | ADDRESS<br>16 N. Bond St.                                    |   |

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive  
cardiovascular disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inspection & inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Joseph P. Jachimczyk

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
7-30-53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

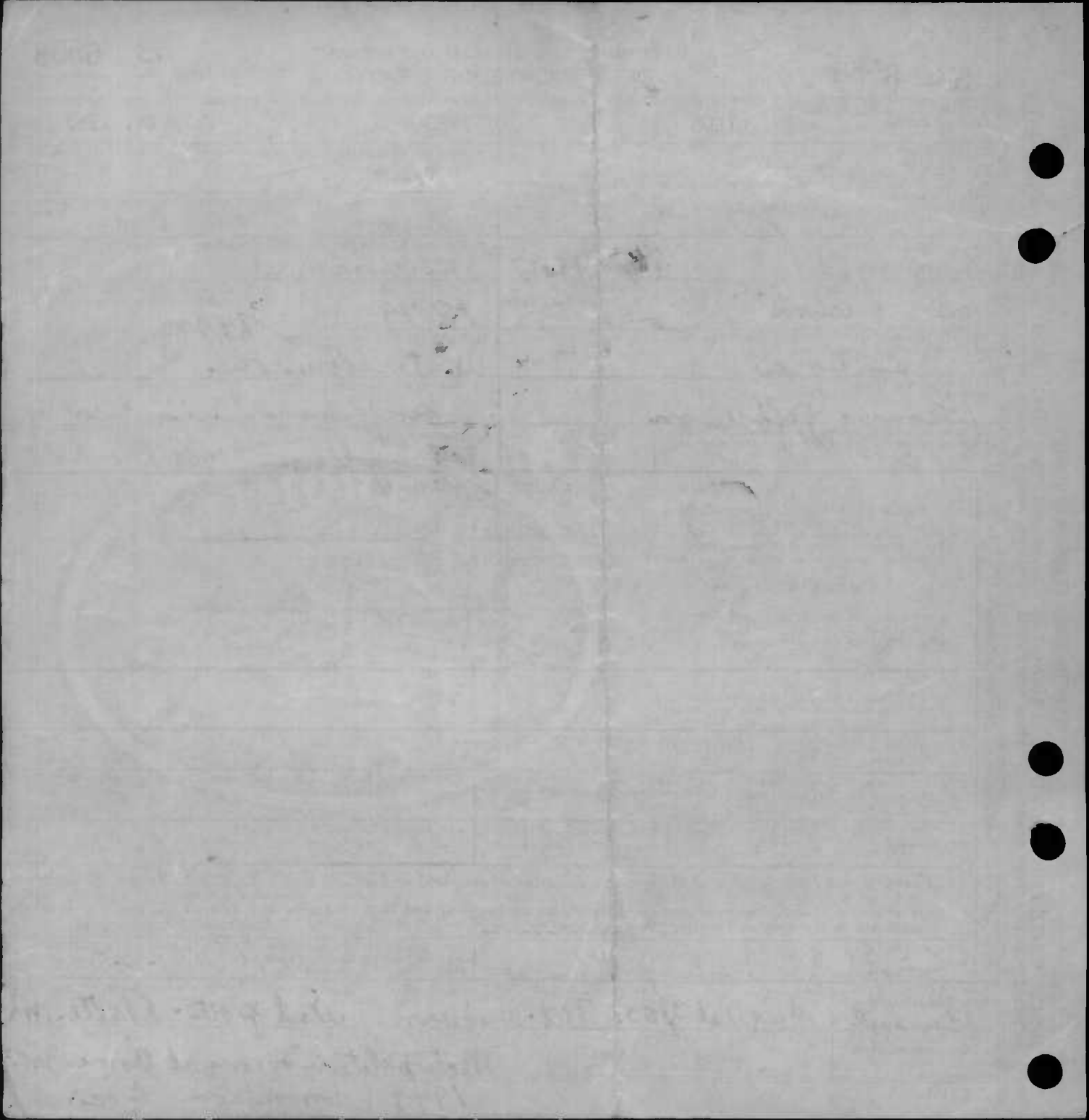
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

970991949 Edmondson Ave.



H-120

53 6989

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6989

BIRTH NO.

|   |                           |   |   |  |  |
|---|---------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Carrie Habbs</i>  |                           |   | 2. DATE OF DEATH <i>Aug 1, 1953</i>   |  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                           |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Howard</i> |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Washburn Avenue</i>   |                           |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Guilford</i>                                     |  |  |
| c. Length of stay in Baltimore<br>Yrs. Mos. Days  |                           |   | D. STREET ADDRESS (If rural, give location)<br><i>6300</i>  |  |  |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>widowed</i> | 8. DATE OF BIRTH<br><i>Dec 31, 1881</i>   | 9. AGE (In years last birthday)<br><i>71</i> | 10. Under 1 Year Months: Days              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Same</i>                  | 11. BIRTHPLACE (State or foreign country)<br><i>Woodbine, Md</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |
| 13. FATHER'S NAME<br><i>Arnon Habbs</i>   |                           |   | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Gannell</i>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>                                  |                           | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><i>Mrs Earl Murphy, 510 Washburn Ave</i>   |  |  |

18. *163X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

*Cardio Respiratory Failure**Emaciation**Carcinoma Lung - Bilateral*

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 2*, 1953, to *Aug 1*, 1953, that I last saw the deceased alive on *July 31*, 1953, and that death occurred at *7:15* a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH

Blank lined form with horizontal ruling lines and four binder holes on the right side.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

T-616

53 6980

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6980

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

TRAEUBER, JOHN C.

2. DATE  
OF  
DEATH

7/31/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

60 years

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

retired Clerk M & E. Co.

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

212-05-4897

8. DATE OF BIRTH

Oct 29, 1889

9. AGE (In years  
last birthday)

63

11 Under 1 Year  
Months Days

11 Under 24 Hours  
Hours Min.

11. BIRTH PLACE (State or foreign country)

Chila, Penna U. S. A.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral vascular accident  
DUE TO cerebral arteriosclerosis  
& hypertensive vasc. disease  
(B) congestive heart failure  
DUE TO coronary arteriosclerosis  
(C)

24 hrs.  
16 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 7/30, 1953 to 7/31, 1953 that I last saw the  
deceased alive on 7/31, 1953, and that death occurred at 3:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Larry B. Scott

M. D.

Mercy Hospital

7/31/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 3 1953

Huntington Williams

Spring Byers 5005 Pk. Heights





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53 6991

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6991

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY T. SMITH

2. DATE  
OF  
DEATH

8/2/53

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore M.G.H.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

4137 MARK AVE 27-01

D. STREET ADDRESS (If rural, give location)

4137 MARK AVE #6

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jun 17. 1879

9. AGE (in years last birthday)

74

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Seis

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 6991

215-03-6991 4137 MARK AVE #6

17. INFORMANT

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastric enteritis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) A.C.V.D. with annular jet  
vibrator  
Dracapsus uterus

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7/25, 1953 to 1.45 pm 8/2 1953 that I last saw the deceased alive on 8/2, 1953, and that death occurred at 1.45 pm, from the causes and on the date stated above.

23A. SIGNATURE

T. A. Taylor M. D.

23B. ADDRESS

23C. DATE SIGNED

8/3/53

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 3 1953

Philip Herwig Sons Orleans St

MARY T. SMITH

GREENSBORO, N.C.

DECEMBER 10, 1917

TO THE EDITOR OF THE

GREENSBORO RECORD

GREENSBORO, N.C.

DECEMBER 10, 1917

YOUR ISSUE OF

DECEMBER 10, 1917

CONTAINS AN

INTERESTING

ARTICLE ON

THE HISTORY OF

GREENSBORO

AND THE

RECORD OF

THE CITY

OF GREENSBORO

AND THE

RECORD OF

THE CITY

OF GREENSBORO

AND THE

RECORD OF

THE CITY

OF GREENSBORO

AND THE

RECORD OF

THE CITY

OF GREENSBORO

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITHOUT UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-420  
MAF-167096  
53 6932

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

53 6932  
Registered No.

|  |                               |   |   |
|--|-------------------------------|---|---|
| BIRTH NO.  |                               | 2. DATE OF DEATH <b>July 31, 1953</b>   |   |
| 1. NAME OF DECEASED (Type or Print) <b>William Mills</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b>  |                               | D. STREET ADDRESS (If rural, give location) <b>5042 Orville Ave.</b>  |   |
| c. Length of stay in Baltimore <b>15 yrs.</b>  |                               | Yrs. Mos. Days  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  | 8. DATE OF BIRTH <b>Dec. 20, 1882</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired boiler helper</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>  | 9. AGE (in years last birthday) <b>70</b> |
| 11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME <b>William Mills (dec.)</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Christine Laughlin (dec.)</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>224-09-2853</b>  |   |
| 17. INFORMANT <b>B. C. H. 4940 Eastern Ave. (records)</b>  |                               | ADDRESS   |   |
| 18. <b>241X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Status Asthmaticus</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                               | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION <b>7-31-53</b>  |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               | IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                               | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>1-24</b> , 19 <b>53</b> to <b>7-31</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-31</b> , 19 <b>53</b> , and that death occurred at <b>6:50A m.</b> , from the causes and on the date stated above.  |                               |   |   |
| 23A. SIGNATURE <b>H. J. Williams, M.D.</b>   |                               | 23B. ADDRESS <b>4940 Eastern Ave. Balto., Md.</b>   |   |
| 23C. DATE SIGNED <b>7-31-1953</b>  |                               | 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |   |
| 24B. DATE <b>8/3/53</b>  |                               | 24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>  |   |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>   |                               | 25. FUNERAL DIRECTOR <b>Philip Herwig Sons</b>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR <b>AUG 3 1953</b>   |                               | REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>  |   |
| VS 150   |                               | ADDRESS <b>2024 Orleans St</b>  |   |
| 690-3U   |                               | 31  |   |

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **6863**

BIRTH NO. **53 6853**

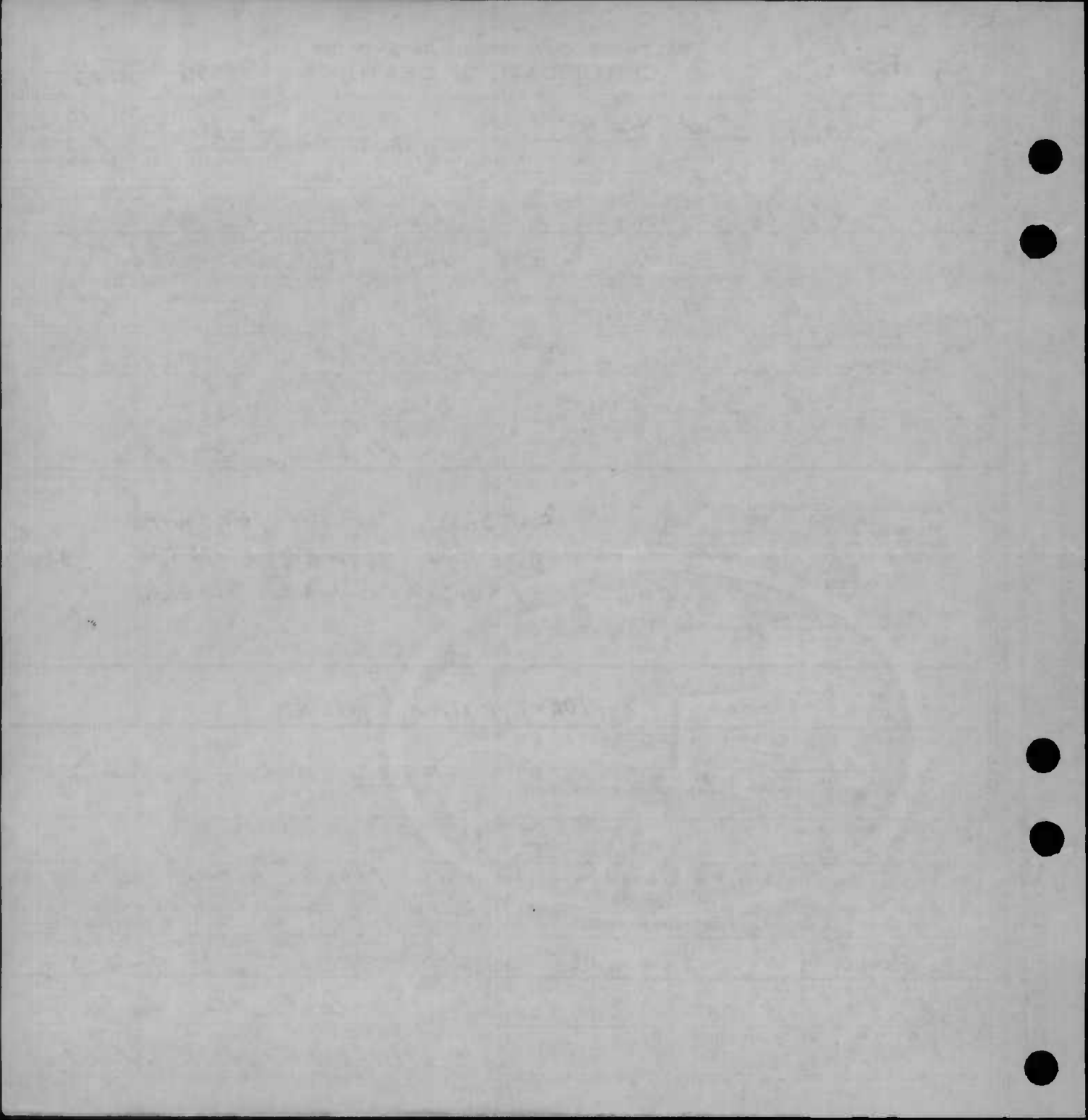
|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY SWAYNE</b>   |                                  |   | 2. DATE OF DEATH <b>Aug. 2, 1953</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Balt. City Hosp.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 8-07</b>                       |  |   |
| c. Length of stay in Baltimore <b>Life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>2026 Ellsworth Street - #13</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>Sept. 15, 1890</b>   | 9. AGE (In years last birthday)<br><b>62</b> | 10. BIRTHPLACE (State or foreign country)<br><b>Balt. Md.</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Charwoman</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Central Ins. Co.</b>  |  |   |
| 11. FATHER'S NAME<br><b>Ferdinand Kress</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Vogel</b>  |  |   |
| 15. SOCIAL SECURITY NO.   |                                  |   | 17. INFORMANT<br><b>Thomas G. Swayne - 534 Southern Ave</b>   |  |   |

|   |   |                                  |
|---|---|----------------------------------|
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC DECOMPENSATION</b> | CAUSE OF DEATH<br>(A) <b>CARDIAC DECOMPENSATION</b><br>DUE TO <b>DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE</b> | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>HYDROTHORAX, BILAT.</b>  | (B) _____<br>DUE TO _____<br>(C) _____  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |                                  |

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that I took charge of the remains described above, held an <b>PARTIAL AUTOPSY</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph A. Lachin</b>   |   | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR..... |  | 23C. DATE SIGNED<br><b>8-2-53</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>8-5-53</b>  | 24C. NAME OF SEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Eastern Ave. - Balt. Md.</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   | 25. FUNERAL DIRECTOR<br><b>John C. Miller Inc.</b>  |  | ADDRESS<br><b>2431 E. Oliver St.</b>  |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6954

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Anderson Mr. Henry Claton2. DATE  
OF  
DEATH1953 August 2 19

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Balto City, Md

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Josephs HospitalYrs.  
Mos.  
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

MarylandBalto

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

2520 E. Oliver St. #13

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 16, 1879

9. AGE (In years last birthday)

7410 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pensioned P.R.R.Co

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hyattsville, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Richard Anderson

14. MOTHER'S MAIDEN NAME

Mrs. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
707-07-6839

17. INFORMANT

ADDRESS

Lillie A. Anderson - 2520 East Oliver St.18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Myocardial Infarction, due to coronary

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

(B) thrombosis

DUE TO

(C) Generalized ArteriosclerosisII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from July 31, 1953 to Aug. 2, 1953 that I last saw the deceased alive on Aug. 2, 1953, and that death occurred at 1:05 A.M. from the causes and on the date stated above.

23a. SIGNATURE

Louis A. Frits

M. D.

23b. ADDRESS

St. Josephs Hospital

23c. DATE SIGNED

Aug. 2, 1953

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

8-5-53

24c. NAME OF CEMETERY OR CREMATORY

London Park Cem.

24d. LOCATION (City, town, or county) (State)

Frederick Rd. - Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

John C. Miller Inc. - 2431 E. Oliver St.

STATE OF TEXAS  
COUNTY OF DALLAS

CERTIFICATE OF DEATH

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6885

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ada G. Reynolds

2. DATE  
OF  
DEATH

July 31, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

3309 Winterbourne Road Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

Baltimore, Md.

C. Length of stay in Baltimore

MR. Louis C. Reynolds

Yrs.  
Mos.  
Days

O. STREET ADDRESS (If rural, give location)

same

16-07

5. SEX

Female

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Nov. 10, 1880 72 years

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Gibbins

14. MOTHER'S MAIDEN NAME

Janet Yost

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

Mr Louis C. Reynolds

ADDRESS

same

18. 252.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Thyrotoxicosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

19A. DATE OF OPERATION

July 30, 1953

19B. MAJOR FINDINGS OF OPERATION

Toxic diffuse Goiter

20. AUTOPSY

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1953, to July 31, 1953 that I last saw the deceased alive on July 31, 1953, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Haverly S. Green, Jr.

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

July 31, '53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8. 4. 1953

24C. NAME OF CEMETERY OR CREMATORY

MOUND HILL

24D. LOCATION (City, town or county)

EATON.

(State)

OHIO

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

J. Howard Strong 3207 W North Ave.

ADDRESS

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D. C.  
CERTIFICATE OF DEATH

|  |  |                                |  |                                     |  |
|--|--|--------------------------------|--|-------------------------------------|--|
| 1. Name of deceased                    |  | 2. Sex                         |  | 3. Age                              |  |
| 4. Date of death                       |  | 5. Place of death              |  | 6. Cause of death                   |  |
| 7. Signature of attending veterinarian |  | 8. Signature of owner          |  | 9. Signature of official            |  |
| 10. Date of report                     |  | 11. Name of reporting official |  | 12. Signature of reporting official |  |
| 13. Name of establishment              |  | 14. Address                    |  | 15. City                            |  |
| 16. State                              |  | 17. County                     |  | 18. Zip                             |  |
| 19. Name of owner                      |  | 20. Address                    |  | 21. City                            |  |
| 22. State                              |  | 23. County                     |  | 24. Zip                             |  |
| 25. Name of establishment              |  | 26. Address                    |  | 27. City                            |  |
| 28. State                              |  | 29. County                     |  | 30. Zip                             |  |
| 31. Name of owner                      |  | 32. Address                    |  | 33. City                            |  |
| 34. State                              |  | 35. County                     |  | 36. Zip                             |  |
| 37. Name of establishment              |  | 38. Address                    |  | 39. City                            |  |
| 40. State                              |  | 41. County                     |  | 42. Zip                             |  |
| 43. Name of owner                      |  | 44. Address                    |  | 45. City                            |  |
| 46. State                              |  | 47. County                     |  | 48. Zip                             |  |
| 49. Name of establishment              |  | 50. Address                    |  | 51. City                            |  |
| 52. State                              |  | 53. County                     |  | 54. Zip                             |  |
| 55. Name of owner                      |  | 56. Address                    |  | 57. City                            |  |
| 58. State                              |  | 59. County                     |  | 60. Zip                             |  |
| 61. Name of establishment              |  | 62. Address                    |  | 63. City                            |  |
| 64. State                              |  | 65. County                     |  | 66. Zip                             |  |
| 67. Name of owner                      |  | 68. Address                    |  | 69. City                            |  |
| 70. State                              |  | 71. County                     |  | 72. Zip                             |  |
| 73. Name of establishment              |  | 74. Address                    |  | 75. City                            |  |
| 76. State                              |  | 77. County                     |  | 78. Zip                             |  |
| 79. Name of owner                      |  | 80. Address                    |  | 81. City                            |  |
| 82. State                              |  | 83. County                     |  | 84. Zip                             |  |
| 85. Name of establishment              |  | 86. Address                    |  | 87. City                            |  |
| 88. State                              |  | 89. County                     |  | 90. Zip                             |  |
| 91. Name of owner                      |  | 92. Address                    |  | 93. City                            |  |
| 94. State                              |  | 95. County                     |  | 96. Zip                             |  |
| 97. Name of establishment              |  | 98. Address                    |  | 99. City                            |  |
| 100. State                             |  | 101. County                    |  | 102. Zip                            |  |

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 53 6886

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Justus Weisenborn

2. DATE  
OF  
DEATH

July 31 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR  
INSTITUTION

2903 Fair Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

1-01

D. STREET ADDRESS (If rural, give location)

2903 Fair Ave

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 23 1878

9. AGE (in years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

National Can Co.

BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Franz Weisenborn

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-01-8568

17. INFORMANT

ADDRESS

Mrs Mary Weisenborn 2903 Fair Ave

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Myocardial

Mar 4 1949

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Pulmonary Tuberculosis

1952

(C)

Tuberculosis Fungus Abscess

1952

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from March 18, 1949, to July 31, 1953, that I last saw the  
deceased alive on July 25, 1953, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Chester B. Hudson

23B. ADDRESS

3426 Baulk

23C. DATE SIGNED

July 31-53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug 3/53

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery Eastern Ave Balto Md

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

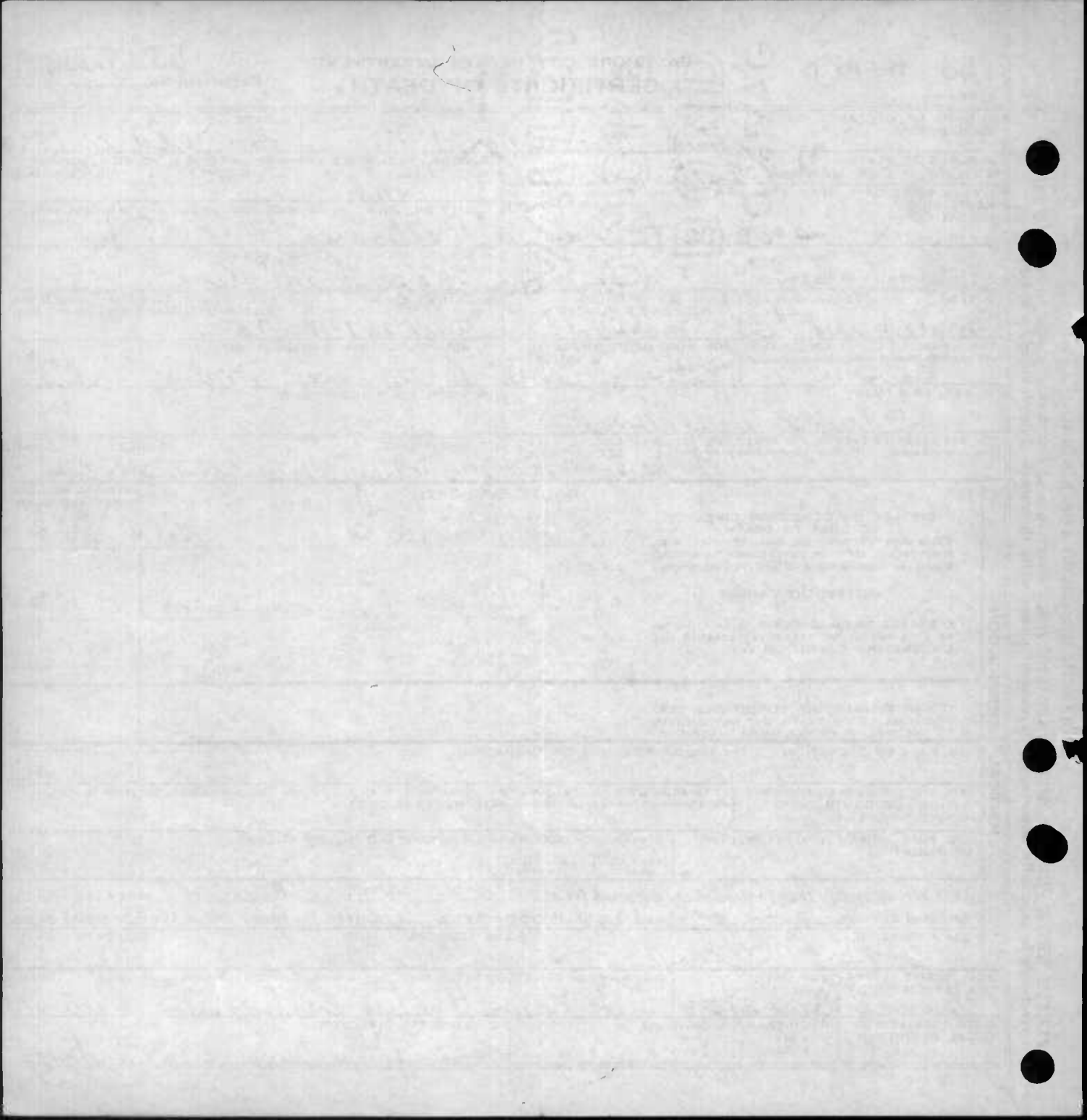
Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

John J. Ruda Inc 2829 Hudson

AUG 3 1953  
VS 150





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 53 6997

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Margret Livingston Sherrer

2. DATE  
OF  
DEATH

August 1, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4022 Roland Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4022 Roland Avenue

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 18, 1883

9. AGE (In years  
last birthday)

69

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John Leo Livingston

14. MOTHER'S MAIDEN NAME

Mary Forien

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Martin V. Sherrer

ADDRESS

4022 Roland Avenue

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Right Cerebral Thrombosis

4 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cardio-renal hypertensive disease

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 31, 1953, to Aug. 1, 1953, that I last saw the  
deceased alive on Aug. 1, 1953 and that death occurred at 3:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Wilson

M. D.

23B. ADDRESS

617 W. 40th St.

23C. DATE SIGNED

8/1/53

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Aug. 4, 1953

24C. NAME OF CEMETERY OR CREMATORY

St. Joseph's

24D. LOCATION (City, town, or county)

Texas, Baltimore Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Burgee Funeral Home 3631 Falls Road

Norace F. X. Burgee

100-100000

RECEIVED BY THE U.S. DEPT. OF JUSTICE  
JAN 10 1961

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S-326.  
53 6958BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH53 6958  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **LEWIS E. SWETZER**2. DATE  
OF  
DEATH **8/1/53**

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR **USPHS Hospital**  
INSTITUTION**Wyann Pk. Dr. and 31st Street**4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **Md.**  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**D. STREET ADDRESS (If rural, give location)  
**4416 KAVON AVE.**c. Length of stay in Baltimore **2½ yrs.**

5. SEX

**male**

6. COLOR OR RACE

**white**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
**married**

8. DATE OF BIRTH

**1/20/05**9. AGE (In years  
last birthday)**48**If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**Rec. Clerk**10B. KIND OF BUSINESS OR  
INDUSTRY**Maryland Club**

11. BIRTHPLACE (State or foreign country)

**Penn.**12. CITIZEN OF  
WHAT COUNTRY?**USA**

13. FATHER'S NAME

**Charles Sweitzer**

14. MOTHER'S MAIDEN NAME

**Maude Miller**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**Yes****1942 - 1943**16. SOCIAL  
SECURITY NO.**187-09-8738**17. INFORMANT ADDRESS  
**Record - USPHS Hospital, Balto., Md.**18. **453.1**DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

**Thrombosis of aorta, left iliac and  
femoral artery**(A) DUE TO **Thromboangitis obliterans**INTERVAL BETWEEN  
ONSET AND DEATH**76 hrs.**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

**4 yrs.**

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

**7/29/53**19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED**Thrombosis of aorta**IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/29** 19**53**, to **8/1** 19**53**, that I last saw the  
deceased alive on **8/1** 19**53**, and that death occurred at **3:55A** m., from the causes and on the date stated above.

23A. SIGNATURE

**David J. Crosby, S.A. Surgeon**

M. D.

23B. ADDRESS

**USPHS Hospital, Balto., Md.**

23C. DATE SIGNED

**8/1/53**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**burial**

24B. DATE

**8/4/53**

24C. NAME OF CEMETERY OR CREMATORY

**U. S. National Cemetery**

24D. LOCATION (City, town, or county)

**Baltimore,**

(State)

**Maryland**DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D. Wm. Cook, Jr.**

25. FUNERAL DIRECTOR

**1217 St. Paul Street**

VS 150

3908X

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH NON-FADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1915

1915

Grand Hotel, 10. and 11th Street  
Grand Hotel

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

# CERTIFICATE CORRECTED 3-15-54

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

53 6959

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George E. Pohler, Sr.

2. DATE  
OF  
DEATH

July 31, 1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

413 E. Lorraine Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

413 E. Lorraine Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec. 12, 1883

9. AGE (in years last birthday)

69

10 Under 1 Year Months: Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor - Circulation

10B. KIND OF BUSINESS OR INDUSTRY

Sun Papers

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Bernard

Peter Pohler

14. MOTHER'S MAIDEN NAME

Catherine Sarah Frances Fortman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lavinia M. Pohler, 413 E. Lorraine Ave

18.

420.1  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

immediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

unknown

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31/1953 to 7/31/1953, that I last saw the deceased alive on 7/30/53, 1953, and that death occurred at 8:50 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

8/4/53

Meadowridge Cemetery

Dorsey,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 3 1953

Huntington Williams, Jr.

Wm. Cook, Inc., 1217 St. Paul Street

VS 150

2904M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A. 68048  
1883



AB-169121

53 7000

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

53 7000

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marcus Luber

2. DATE  
OF  
DEATH

8-2-1953

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1929 W. Franklin St. zone 17

c. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 4-1872

9. AGE (In years  
last birthday)

81

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Ret. Laborer - Bridge Dept. Balto. City

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Marcus Luber

14. MOTHER'S MAIDEN NAME

Emma Cranall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.17. INFORMATION  
Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 454X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Acute congestive cardiac failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Thrombosis right common iliac artery

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-30-1953 to 8-2-1953 at I last saw the  
deceased alive on 8-2-1953 and that death occurred at 7.05A m., from the causes and on the date stated above.

23A. SIGNATURE

H. J. Johnson, M.D.

23B. ADDRESS

4940 Eastern Ave., Baltimore, Md.

23C. DATE SIGNED

8-2-1953

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/5/53

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

Dorsey Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Cook Inc. 1217 St. Paul St.

ADDRESS

VS 150

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITHOUT UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

00-1140

12-1-1961

Memorandum

Subject:

1. The purpose of this memorandum is to inform you of the results of the investigation conducted by the FBI on the matter of the alleged activities of the [redacted] in the [redacted] area.

2. The investigation was conducted by the [redacted] and the [redacted] of the FBI.

3. The results of the investigation are as follows:

a. [redacted]

b. [redacted]

c. [redacted]

d. [redacted]

e. [redacted]

f. [redacted]

4. It is recommended that the [redacted] be [redacted] in the [redacted] area.

5. The investigation was completed on [redacted] and the results are being reported to you for your information.

Very truly yours,

Special Agent in Charge

Enclosure